

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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2015
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 02/10/15 and concluded on 02/12/15 with deficiencies cited at the highest scope and severity of a "D".	F 000	The submission of this plan of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents at Glen Ridge. The facility recognizes its obligations to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements for participation in title 18/19 programs. To this end, this plan of correction (POC) shall serve as the credible allegation of compliance with all state and federal requirements governing the management of the facility. It is thus submitted as a matter of statute only.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop care plans for two (2) of sixteen (16) sampled residents (Residents #9 and #11). The facility failed to develop a care plan for Resident #9's Depression, and use of oxygen and a trilogy	F 279	1.) Resident #9's care plan was updated on 2/11/15 by MDS Coordinator and has since been discharged. Resident #11's care plan was updated by MDS Coordinator on 2/10/15 to reflect interventions regarding Contact Precautions	

3-26-15
per R. M...
3/25/15
by RB 3-1-15
(X6) DATE

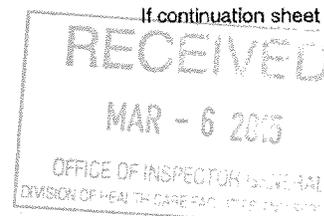
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE X Executive Director
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>ventilator. In addition the facility failed to develop a care plan for Resident #11's Contact Precautions.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Standard Precaution, dated December 2010, revealed upon verification that a resident required Contact Precautions, the care plan would be updated.</p> <p>Observation during the initial tour, on 02/10/15 at 9:00 AM, revealed Resident #11 was diagnosed with a Urinary Tract Infection with Vancomycin Resistant Enterococcus (VRE) and required Contact Precautions per the physician orders.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident on 12/31/14 with diagnoses of Stage II Kidney Disease, Hypertension, and Heart Failure. The facility completed an admission Minimum Data Set (MDS) assessment, dated 01/07/15, which revealed the resident required extensive assistance with dressing, bathing, transfers and eating. The resident was frequently incontinent of bladder and wore briefs. The facility assessed the resident as cognitively impaired with a score of nine (9) out of fifteen (15) on the Brief Interview for Mental Status (BIMS); however, the resident was interviewable. The resident used the main dining room for meals and was encouraged to attend activities.</p> <p>Review of Resident #11's comprehensive care plan, dated 01/13/15, revealed the resident had a Urinary Tract Infection and was in Contact Precautions with altered cognition; however, no information was located in the care plan</p>	F 279	<p>F279 cont.</p> <p>2.) Residents who have depression, use oxygen a trilogy ventilator, or are in contact precautions will be audited by Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator to ensure that care plans are accurate and up to date. The audits will be completed on or before March 25th, 2015.</p> <p>3.) Residents who have depression, use oxygen a trilogy ventilator, or is in contact precautions, will have a care plan initiated by the charge nurse, MDS, Director of Health Service, or Assistant Director of Health Services to reflect the resident's current condition. Care plan meetings will be held for each resident quarterly and care plans will be updated as necessary by the Interdisciplinary Care Plan Team at that time and as changes occur. Nursing, Social Services, and MDS staff will be in-serviced by Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator, on Interdisciplinary Team Care Plan Guideline on or before March 25th, 2015. This in-service will focus on initial plan of care procedure including, initial plans of care, care planning changes in a resident's status, and how to develop an accurate comprehensive care plan which includes, comprehensive assessments, measurable and obtainable goals, appropriate interventions which establish individual needs and risk influence, and care plan reviewing to ensure that the care plans remain accurate.</p>	<p>3-26-15 P.R. Mullins 3/25/15 KJPB 3-6-15</p>	

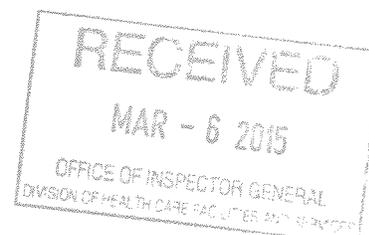


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F 279	<p>Continued From page 2 regarding the contact precautions and the interventions needed to provide care safely. In addition, there were no interventions for assisting the resident to perform hand hygiene or what to do to prepare the resident for trips outside the resident's room since the facility allowed the resident to be outside the contact precautions for facility functions and meals.</p> <p>Observation of Resident #11, on 02/11/15 at 4:30 PM, revealed the resident was fully dressed on the bed and the resident's eyes were closed.</p> <p>Observation of Resident #11, on 02/11/15 at 4:26 PM, revealed the bathroom call light was sounding. Certified Nurse Aide (CNA) #4 entered the room without a gown and went into the bathroom. A few moments later, the CNA pushed the resident's wheelchair out of the bathroom and placed the resident near the bed. The CNA removed her gloves and held her hands up and on her chest and walked out of the room without performing hand hygiene.</p> <p>Interview with CNA #4, on 02/11/15 at 4:30 PM, revealed she had not washed her hands prior to leaving the resident's room until requested to do so. She indicated that she preferred not to use the resident's bathroom for handwashing. She stated she preferred to go down the hall to an employee bathroom to wash her hands. She stated she entered the bathroom to clean the resident after the resident voided and to assist the resident into the wheel chair and back to the bedside. She indicated she wore gloves to complete this task. She indicated she did not know she needed to wear a gown. She stated she was not aware the resident had a VRE infection in the urine or that the microorganism</p>	F 279	<p>F279 cont. 4.) The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will utilize the Care Plan Audit Tool to ensure that any resident that has a diagnosis of depression, uses oxygen, a trilogy ventilator, or is in contact precautions has a comprehensive care plan completed as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed and monitored during the monthly Quality Assurance Meeting. If non-compliance is found, then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>		

*3-26-15
Per R Mullins
by PB 3-6-15
3/25/15*



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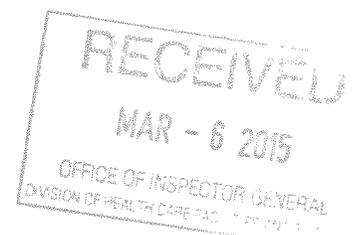
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F 279	<p>Continued From page 3</p> <p>was resistant to some antibiotics. She stated there was nothing specific on the resident's care plan regarding how to provide care for a resident in contact precautions or how to prevent the spread of microorganisms. She stated the resident ate meals in the dining room with other residents. She indicated there were no interventions regarding how to safely take the resident to the dining room or activities nor were there interventions regarding handwashing for the resident prior to trips outside the contact precautions room. She stated she was trained on contact precautions about a year ago.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 02/11/14 at 4:45 PM, revealed Resident #11 had an infection requiring contact precautions. She stated CNA #4 should have worn a gown and gloves for perineal care after the resident toileted. She indicated she supervised the CNAs and staff should follow the policy regarding contact precautions. She stated she was not sure what interventions were on the resident's care plan and she would have to review the care plan. She indicated all nurses were responsible for writing the residents' care plans. She stated she had received training on developing care plans.</p> <p>Interview with the Director of Nursing, on 02/11/15 at 4:56 PM, revealed nursing staff were to wear gloves and gown if they provided direct contact care for residents in contact precautions and perineal care was certainly direct contact care. She stated the care plan should include interventions; however, the nursing staff were familiar with precautions. She revealed Resident #11 was free to attend meals and activities in the facility. She was not aware the care plan for contact precautions did not contain interventions</p>	F 279			



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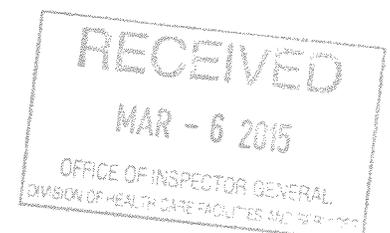
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F 279	<p>Continued From page 4</p> <p>for care of the resident. She indicated all nurses were responsible for writing care plans for residents. In addition, all physician orders were reviewed in a daily meeting of nurse managers and care plans were reviewed for content.</p> <p>2. Review of the facility's policy and procedure regarding Clinical Documentation Systems, not dated, revealed the interdisciplinary team would plan care and treatment to ensure appropriateness of services to meet the residents' needs, and address the severity of conditions, impairment, disability or disease. The care and treatment planning process would be comprehensive and designed to meet the individual needs of the resident and promote independence and prevent decline in physical and mental functioning. Additional review revealed ongoing assessments would be completed daily and in the event of an incident or change in medical condition the care plans would be updated as needed.</p> <p>Review of the clinical record for Resident # 9 revealed the facility admitted the resident on 01/21/15 with diagnoses of Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension and Anxiety.</p> <p>Review of an Admission Minimum Data Set (MDS) assessment, dated 01/28/15, revealed the facility assessed Resident #9 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable. Further review revealed the facility had assessed Resident #9's mood with a Patient Health Questionnaire -nine (PHQ-9) score of ten (10), indicating the resident reported feelings of</p>	F 279		



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F 279	<p>Continued From page 5 moderate Depression.</p> <p>Review of a Physician's Progress Note, dated 02/03/15, revealed Resident #9 received a Psychiatric Evaluation to evaluate complaints of Anxiety and Depression. Further review revealed new orders for Cymbalta (Antidepressant) thirty (30) milligrams (mg) for seven (7) days, then increase to sixty (60) mg.</p> <p>Review of the Comprehensive Care Plan, dated 02/03/15, revealed an intervention which stated Cymbalta as ordered; however, there was no evidence the Comprehensive Care Plan addressed the Depression.</p> <p>Interview with the Social Services Director, on 02/12/15 at 4:10 PM, revealed the facility assessed Resident #9 as Depressed; however, she stated the care plan did not address Depression because the resident did not have the diagnosis of Depression. However, they would have updated the care plan with his/her next quarterly review. The Social Services Director stated the care plan should have been updated to reflect the new change of Depression and it would have been her responsibility to do so.</p> <p>Interview with the Executive Director, on 02/12/15 at 5:10 PM, revealed changes in resident's conditions are monitored daily by the nursing staff through assessment and all residents with a change in condition are discussed each day in a clinical meeting. She further stated it was her expectation that once a change or a new problem had been identified the resident's care plan would be revised to include the new problem, interventions would be implemented and the care plan would be monitored and evaluated for a</p>	F 279			

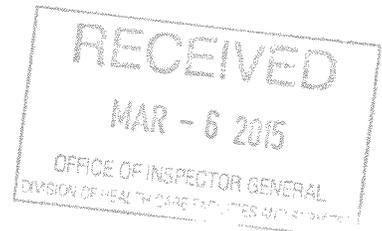


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F 279	Continued From page 6 response.	F 279			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, it was determined the facility failed to ensure qualified licensed staff administered a respiratory treatment for one (1) of one (1) unsampled resident (Unsampled Resident A) related to a nebulizer treatment administered by a Certified Medication Technician (CMT).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure regarding Respiratory/Inhalation Treatment Guidelines, dated January 2006, revealed aerosol breathing treatments would be administered to residents as ordered by the physician by a licensed nurse. Further review revealed state regulatory guidelines would be followed to ensure appropriate assessment, administration, and documentation.</p> <p>Review of the clinical record for Unsampled Resident A revealed the facility admitted the resident on 01/21/15 with diagnoses of Pneumonia, and Congestive Heart Failure.</p>	F 282	<p>F282</p> <p>1.) Unsampled Resident A was not harmed and continues to receive care at facility. Education was provided to the CMT on 2/10/15, regarding scope of practice for a CMT, by Assistant Director of Nursing. Nurse in charge was also educated on 2/10/15, by the Assistant Director of Health Services.</p> <p>2.) An audit of residents who receive respiratory treatments, including nebulizers, will be completed by the Director of Health Services, Assistant Director of Health Services, or the Staff Development Coordinator on or before March 25th, 2015, to ensure that all treatments are being administered by a qualified personnel.</p> <p>3.) CMT's will not administer respiratory treatments, including nebulizers. Respiratory treatments, including nebulizers will only be administered by qualified personnel which includes; LPN's or RN's. Nursing Staff will be in-serviced, by Director of Health Services, Assistant Director of Health Services, or the Staff Development Coordinator on Scope of Practice for CMT's, LPN's, and RN's on or before March 25th, 2015.</p>		

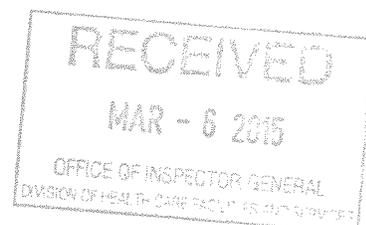
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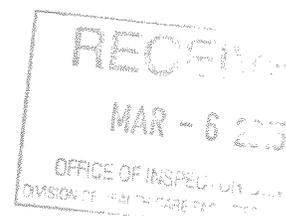
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F 282	Continued From page 7 Observation of a medication pass, on 02/10/15 at 3:55 PM, revealed CMT #1 entered Unsampld Resident A's room and administered a nebulizer treatment, DuoNeb 2.5/5 milligrams (mg). Interview with CMT #1, on 02/12/15 at 2:36 PM, revealed she had been trained by the facility to administer nebulizer treatments. Interview with the Director of Nursing (DON), on 02/12/15 at 5:20 PM, revealed it was her expectation and the facility's policy and procedure that all respiratory treatment were to be administered by a licensed nurse. She stated that CMT's should not administer respiratory treatments, it was out of their scope of practice due to the need to monitor and assess the resident before, during, and after a treatment.	F 282	F282 cont 4.) Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will utilize the Respiratory Treatment Audit Tool to ensure that respiratory treatments, including nebulizers, will only be administered by qualified staff. These audits will continue weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility Quality Assurance meeting. If non-compliance is found, then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide medications and treatments to two (2) of sixteen (16) sampled residents (Residents #3 and #9). The facility failed to administer Flonase as	F 309	F309 1.) Resident #3 was not harmed and continues to receive care at facility. The Flonase for the resident was obtained on 12/3/14 and resident continues on medication as ordered. Order was obtained on 2/11/15 for the oxygen and trilogy ventilator on Resident #9 as follows; Trilogy vent per home settings at bed time with oxygen at 3 liters per nasal canula to be attached to trilogy vent when in use. Resident #9 has since been discharged. 2.) An audit of all MAR's and medication carts will be conducted on or before March 25th, 2015, using the Daily Medication Transcription Audit Tool to ensure that all MAR's are accurate and all medications are available. This will be completed by the Director of Nursing, the Assistant Director of Nursing, or the Staff Development Coordinator.		3/26-15 R. Mullins 3/26-15 3/25/15



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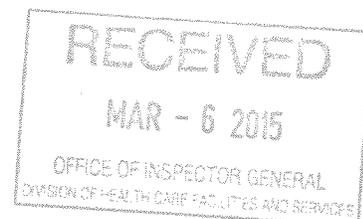
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F 309	<p>Continued From page 8</p> <p>ordered by the physician to Resident #3. In addition, the facility administered oxygen and utilized a ventilator for Resident #9 without physician orders.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Ordering Medications, dated June 2012, revealed when a medication was not available, the staff was to check the emergency medication stock box. Staff was to call the pharmacy and let them know the facility was completely out of the medication and when the next dose was due. It was never acceptable for a dose of medication to be unavailable. The pharmacy recommended to reorder a medication when it was down to a three (3) to four (4) day supply.</p> <p>Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Depression, Anemia, Hypertension, Peripheral Vascular Disease, Allergic Rhinitis and Asthma. The facility completed an admission Minimum Data Set (MDS) assessment which revealed the resident required extensive assistance with daily activities of living and was cognitively intact.</p> <p>Review of the physician orders, revealed Flonase Nasal Spray was ordered by the physician on 11/02/14 for Resident #3's allergies. The Medication Administration Record (MAR) for November 2014, revealed the Flonase order was transcribed and the medication was ordered from the pharmacy. On 11/03/14, it was noted the Flonase was not available and the pharmacy was notified. The November MAR documentation showed the medication was not administered</p>	F 309	<p>F309 cont</p> <p>3.) Nursing staff will be in-serviced by the Director of Health Services, the Assistant Director of Health Services, or Staff Development Coordinator on the Guidelines for Medication Orders on or before March 25th, 2015. Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will check all new orders with the MAR/TAR daily to ensure that all orders are transcribed accurately. Med carts will be checked every 24 hours to make sure that new medications are available. The carts will be checked by the Director of Health Services, Assistant Director of Health Services, Staff Development Coordinator, or Charge Nurse.</p> <p>4.) Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will utilize the Daily Medication Transcription Audit Tool weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility Quality Assurance Meeting. If non-compliance is found, then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>	3/25/15	<p>3-26-15 per R. Mulhro per PB 3-6-15</p>



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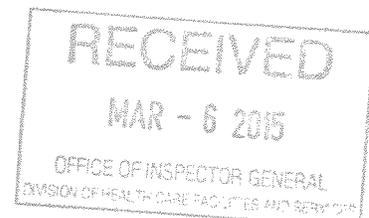
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2015
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F 309	<p>Continued From page 9</p> <p>from 11/03/14 until 11/08/14 and the nurses's initials were circled; however, there was no entries by the nurses' to explain the missed medication. There was no explanation for the medication not being given on 11/09/14 nor was there any circled initials. From 11/10/14 to 11/16/14, the nurses' initials were circled to indicate the medication was not administered. There was an entry by the nurse on 11/15/14 that revealed the Flonase was not located on the medication cart and the pharmacy was notified. The medication was not on the medication cart on 11/16/14 and the nurse notified the pharmacy and was advised that the medication had been sent to the facility. The nursing notes for 11/16/14 revealed the medication was discontinued by the physician.</p> <p>Attempts to interview the Pharmacist by telephone revealed no return calls were received as of exit on 02/12/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/10/14 at 10:45 AM, revealed the medication did not arrive at the facility on 11/02/14 and the pharmacy was notified on 11/03/14. She stated the medication was forgotten and the facility did not call the pharmacy to check on the medication until 11/15/14. The medication was still not at the facility on 11/16/14, when the pharmacy was called and the facility was advised the medication had been sent out to the facility. She stated the physician was notified on 11/16/14 and the medication was discontinued by the physician.</p> <p>Interview with LPN #3, on 02/10/14 at 10:56 AM, revealed the pharmacy was notified of the missing medication on 11/03/14. She stated the</p>	F 309			



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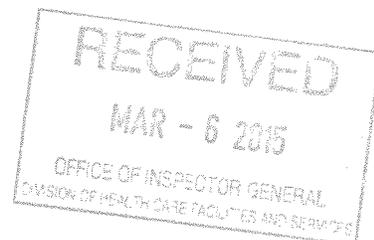
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F 309	<p>Continued From page 10</p> <p>Director of Nursing (DON) should have been notified that the medication was ordered and not received. She indicated nurses were responsible to send the pharmacy orders for medications and if the medications failed to be delivered, the pharmacy was called back and notified that the resident needed the medication and when the next dose was scheduled to be administered. She stated the Director of Nursing would have been involved if the medication continued to be missing. She revealed the nurse should have checked on the medication daily and communicated the information to the charge nurse and the DON. She stated the physician chose to discontinue the medication as the resident had no symptoms of allergic rhinitis.</p> <p>Interview with the DON, on 02/12/14 at 3:10 PM, revealed she was not notified regarding the missing Flonase until 11/16/14 and she instructed the nurse to notify the physician. She stated the nurses should have followed the Medication Reordering Policy and this had not happened.</p> <p>2. Review of the facility's policy and procedure regarding Guidelines for Administration of Oxygen, revised 04/04/14, revealed before oxygen was administered to a resident, the staff would verify the physician's order for the procedure.</p> <p>Review of the clinical record for Resident # 9 revealed the facility admitted the resident on 01/21/15 with diagnoses of Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension and Anxiety.</p> <p>Review of an Admission Minimum Data Set</p>	F 309			



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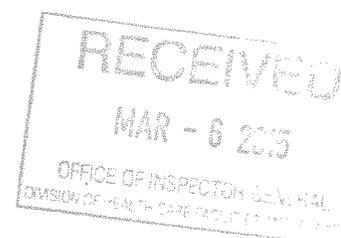
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F 309	Continued From page 11 (MDS) assessment, dated 01/28/15, revealed the facility assessed Resident #9 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable. Observations, on 02/10/15 at 11:23 AM and 4:00 PM, and 02/11/15 at 8:00 AM, revealed Resident #9 was sitting in a chair in his/her room with oxygen being administered via nasal canula. Interview with Licensed Practical Nurse (LPN) #1, on 02/11/14 at 4:28 PM, revealed Resident #9 received Oxygen two (2) Liters per minute and a Ventilator (mechanical ventilator used to provide continuous or intermittent ventilator support) at night due to his/her difficulty breathing. Review of the physician's orders for Resident #9, dated 02/01/15-02/28/15 revealed no evidence of physician's orders for the oxygen or the Ventilator. Interview with LPN #1, on 02/11/15 at 4:35 PM, revealed Resident #9 should have orders for the oxygen administration and for the use of the Ventilator. Interview with the Director of Nursing (DON), on 02/12/15 at 3:45 PM, revealed she would have expected a physician's order to be present for administration of the oxygen and the use of the Ventilator.	F 309			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328	F328 1.) Unsampled Resident A was not harmed and has since discharged from the facility. Education was provided to the CMT on 2/10/15, regarding scope of practice for a CMT by the Assistant Director of Nursing. Nurse in charge was also educated on 2/10/15, by the Assistant Director of Health Services.		3-26-15 Per R. [unclear] by PB 3-2-15 3/25/15



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F 328	<p>Continued From page 12 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, it was determined the facility failed to ensure residents received the necessary care and treatment for one (1) of one (1) unsampled resident, (Unsampled Resident A) related to a nebulizer treatment administered by a Certified Medication Technician (CMT).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure regarding Respiratory Inhalation Treatment Guidelines, dated January 2006, revealed aerosol breathing treatments would be administered to residents as ordered by the physician by a licensed nurse. Further review revealed the state regulatory guidelines would be followed to ensure appropriate assessment, administration, and documentation.</p> <p>Review of the clinical record for Unsampled Resident A revealed the facility admitted the resident on 01/21/15 with diagnoses of Pneumonia, and Congestive Heart Failure.</p>	F 328	<p>F328 cont.</p> <p>2.) An audit of residents who receive respiratory treatments, including nebulizers, will be completed by the Director of Health Services, the Assistant Director of Health Services, or Staff Development Coordinator on or before March 25th, 2015, to ensure that all treatments are being administered by a qualified personnel.</p> <p>3.) CMT's will not administer respiratory treatments, including nebulizers. Respiratory treatments, including nebulizers will only be administered by qualified personnel which includes; LPN's or RN's. Nursing Staff will be in-serviced by Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator, on Scope of Practice for CMT's, LPN's, and RN's on or before March 25th, 2015.</p> <p>4.) Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will utilize the Respiratory Treatment Audit Tool to ensure that respiratory treatments, including nebulizers, will only be administered by qualified staff weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility Quality Assurance meeting. If non-compliance is found, then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>	3/26-15 R. Muller 07/03/15 3/25/15	



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F 328	Continued From page 13 Observation of a medication pass, on 02/10/15 at 3:55 PM, revealed CMT #1 entered Unsampld Resident A's room and administered a nebulizer treatment, DuoNeb 2.5/5 milligrams (mg). Interview with CMT #1, on 02/12/15 at 2:36 PM, revealed she had been trained by the facility to administer nebulizer treatments. Interview with the Director of Nursing (DON), on 02/12/15 at 5:20 PM, revealed it was her expectation and the facility's policy and procedure that all respiratory treatment were to be administered by a licensed nurse. She stated that CMT's should not administer respiratory treatments as it was out of their scope of practice due to the need to monitor and assess the resident before, during, and after a treatment.	F 328			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F441 1.) UA and culture was obtained on 2/12/15 on Resident # 11, and was negative for VRE. The care plan was updated again to reflect the resident's status. Care plan updated by MDS on 2/11/2015. Nurses and CRCA's was educated on 2/11/15 by the Assistant Director of Health Services, on Contact Precautions Guidelines. 2.) An audit will be completed by the Director of Health Services, the Assistant Director of Health Services or the Staff Development Coordinator on or before March 25th, 2015, utilizing the Contact Isolation Audit Tool for residents who require Contact Isolation to ensure that residents who are in need of Contact Isolation are appropriately identified as such and that all PPE needed are identified and available. An audit will also be completed, by the Director of Health Services, the Assistant Director of Health Services, or the Staff Development Coordinator, utilizing the Contact Isolation Audit/Employee Tool to ensure that all employees are using the necessary PPE for Contact Isolation residents. The audits will be completed on or before March 25th, 2015.	3-26-15 per R. Mullins MPB3-15 3/25/15	



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F 441	<p>Continued From page 14</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>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure nursing staff wore personal protective equipment (PPE) of gown and gloves, while providing direct care for one (1) of sixteen (16) sampled residents (Resident #11) with a diagnosis of Vancomycin Resistant Enterococcus Urinary Tract Infection. The facility failed to ensure staff wore gowns when entering the room of a resident in Contact Precautions and who was incontinent of the bladder. In addition, the facility failed to ensure PPEs were located in an area determined to be clean and not inside the resident's Contact Precaution's room.</p>	F 441	<p>F441 cont</p> <p>3.) Director of Health Services, Assistant Director of Health Services, or Staff Development Director will in-service staff on Precaution Categories and Guidelines for Standard Precautions on or before March 25th, 2015.</p> <p>4.) Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will utilize the Contact Isolation Audit Tool to ensure that all residents in need of Contact Isolation has an infectious diagnosis, an order for the contact isolation, appropriate signage, appropriate PPE which includes, gloves, gowns, sugar bags, biohazard bags, and mask. The Contact Isolation Audit/ Employee Tool will also be utilized to ensure that staff are utilizing the appropriate PPE for those residents that are in Contact Isolation weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility Quality Assurance Committee Meeting. If non-compliance is found then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>	3-26-15 Per R. Mullins RYPB32-15 3/25/15	



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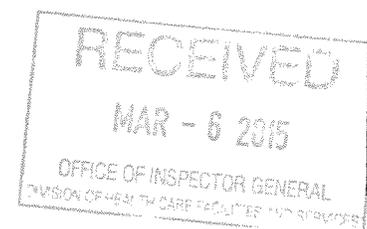
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F 441	<p>Continued From page 15</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Standard Precautions, dated December 2010, revealed Contact Precautions required that a gown would be used when entering a resident's room if: the actively infected individual was incontinent.</p> <p>Review of the facility's policy regarding Contact Precautions, not dated, revealed the precautions were a method designed to prevent the spread of infectious disease organisms by direct or indirect contact. Contact Precautions are indicated to prevent and control nosocomial transmission of Vancomycin Resistant Enterococcus species (VRE). Gloves and gowns were worn when entering the room. A fluid resistant gown was worn if it was anticipated that clothing would have substantial contact with the resident or environmental surfaces or when there was likely contamination of surfaces or items in the room. Staff was to remove their gloves prior to loosening ties on the gown. They were to wash their hands immediately with antimicrobial soap or waterless hand sanitizer.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Congestive Heart Failure, Stage II Chronic Kidney Disease and Hypertension. The resident developed a Urinary Tract Infection with Vancomycin Resistant Enterococcus (VRE) and the physician ordered an antibiotic and Contact Precautions. The facility completed an admission Minimum Data Set (MDS) assessment, dated 01/07/15, which indicated the resident required extensive assistance with daily activities, was frequently incontinent of bladder and had some cognitive impairment as evidenced by a score of</p>	F 441			



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F 441	<p>Continued From page 16</p> <p>nine (9) out of fifteen (15) on a Brief Interview for Mental Status (BIMS).</p> <p>Observation of Resident #11, on 02/11/15 at 4:26 PM, revealed the resident's bathroom call light was sounding. A Certified Nurse Aide (CNA) #4 was walking down the hallway and entered Resident #11's room and went into the bathroom. A few moments later, the CNA pushed the resident's wheelchair out of the bathroom and wheeled the resident near the bed. The CNA was not wearing a gown. The CNA removed her gloves and held her hands up and onto her chest against her shirt and walked out of the room. Handwashing was not observed.</p> <p>Interview with CNA #4, on 02/11/15 at 4:30 PM, revealed she had not washed her hands prior to leaving the resident's room when she was asked to wash her hands. She stated that she preferred to use the bathroom down the hallway and not use the resident's bathroom for handwashing. She stated she entered the resident's bathroom, where she had left the resident in order to clean the resident and assist the resident into the wheel chair and back to the bedside. She indicated she wore gloves to complete the perineal care. She stated she was busy and forgot to don a gown to give the perineal care. She stated she knew the resident had an infection, and she was aware of the risks she took by going down the hallway to perform hand hygiene. She stated there was nothing specific on the resident's care plan regarding how to provide care and prevent spreading the bacteria. She stated she may have come into contact with the resident and the resident's clothing while not wearing a gown. She stated that she had touched her clothing prior to washing her hands. She indicated that she did</p>	F 441			



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F 441	<p>Continued From page 17</p> <p>not know if PPE should be stored inside or outside the contact precautions room; however, she thought storage outside of the room would prevent the PPE from being contaminated.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 02/11/14 at 4:45 PM, revealed Resident #11 had an infection requiring contact precautions. She stated CNA #4 should have worn a gown and used gloves to clean Resident #11 after the resident toileted. She indicated she supervised the CNA and staff should follow the policy regarding contact precautions. She stated she did not see a problem with the PPE being stored inside the isolation room and further was required to follow the facility policies. However, review of the policy revealed it did not dictate where the PPE should be stored while the resident was in isolation.</p> <p>Interview with the Director of Nursing, on 02/11/15 at 4:56 PM, revealed CNAs should wear gloves and a gown if they provided direct contact with residents. She stated that perineal care was direct care and the CNA had received training. She indicated the staff needed increased supervision to ensure facility policy was followed. She stated staff possibly could spread infections related to lack of hand hygiene.</p> <p>Interview with CNA #1, on 02/11/15 at 5:04 PM, revealed she had some recent training on infection control and contact precautions. She stated gowns should be worn if direct contact with the resident during care. She stated she was used to seeing PPE stored in the hall right outside the resident's room, not inside the room. She thought the PPE or the container could get soiled</p>	F 441			

