

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

PRINTED: 03/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203		
(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 A Standard Health Survey was initiated on 02/25/14 and concluded on 02/27/14 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 02/26/14 with deficiencies cited at the highest scope and severity of an "F".	F 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a sanitary, and in good repair, environment during two (2) of two (2) meal observations. During breakfast and lunch meals and tray pass, Housekeeping carts and services and Maintenance carts and services occurred. In addition, dresser drawers were in disrepair for nine (9) of fifty-one (51) residents. The findings include: The facility did not provide a policy for housekeeping or maintenance services. 1. Observation, on 02/25/14 at 12:50 PM, revealed the tray cart was on the hall for rooms 237 through 252 during the lunch meal. Housekeeper #1 had the housekeeping cart out in the hall and was cleaning in a resident's room, Room 245.	F 253	F253 The facility maintains that it provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. No residents were injured and no residents reported negative outcomes related to the alleged deficient practices. All housekeepers and floor technicians received re-education and acknowledged in writing that they read and understood the facility policy to cease services during meals.	3/27/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
X William Wideman
TITLE
X ADMINISTRATOR
(X6) DATE
X 4-1-14

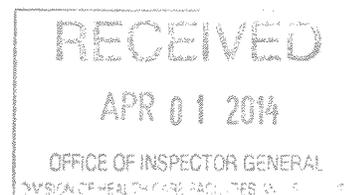
any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 253	<p>Continued From page 1</p> <p>The Floor Technician was also observed using the floor buffing machine (buffer) during the meal tray pass. Residents were observed in the main dining room, near room 252, eating their meal.</p> <p>Additional observation of the breakfast meal, on 02/26/14 at 8:06 AM, revealed Maintenance Technician #2 and the Maintenance Director were on the hall by rooms 237 through 252 with the maintenance cart and drilling a door closure on the hallway. Continued observation, at 8:13 AM, revealed Housekeeper #2 spraying CD10 cleaning solution on the nurse's station counter. Additionally, observation, at 8:16 AM, revealed Maintenance Technician #1 changing ceiling tiles on the hall by room 275. Observation, at 8:25 AM, revealed the Floor Technician dust mopping resident rooms and hallways near room 237.</p> <p>Interview, on 02/27/14 at 11:10 AM, with the Floor Technician revealed the floor could be dusted, mopped, and buffed when the tray carts were not on the floor. He stated the buffer could splatter dust and chemicals and was a risk to get onto the resident's food.</p> <p>On 02/27/14 at 11:18 AM, interview with Housekeeper #1 revealed the housekeeping cart should not be on the floor during meals and tray pass. She stated during meals, cleaning should not be conducted unless there was a spill. The housekeeper indicated as soon as the tray cart came to the floor housekeeping carts should be put away; however, if she was in a room cleaning and did not see the tray cart, someone would need to inform her meal service had begun. Additionally, Housekeeper #1 stated the purpose of placing housekeeping carts away during meal service was to keep the sprays and chemicals</p>	F 253	<p>Re-education conducted by the Director of Environmental Services. The Director of Maintenance and Maintenance Technicians were re-educated by Administrator on the practice of ceasing operations during meal services. Re-education completed March 19, 2014. Systematic changes implemented to ensure that the deficient practices do not recur include: Administrator, Director of Environmental Services and Director of Food Services met regarding the coordination of dietary practices with housekeeping/ maintenance services on 3/17/14. Housekeeping and maintenance services are not to be performed during meal pass delivery or meal times which includes the hours from 7:30 am until 9:00 am, 11:30 am until 1:00 pm and 4:30 pm until 6:00 pm. The facility will monitor compliance with facility policies as follows: Director of Environmental Services, Director of Maintenance, Administrator and the Weekend Manager on Duty will monitor one meal/day for compliance with facility practices for 14 days.</p>	



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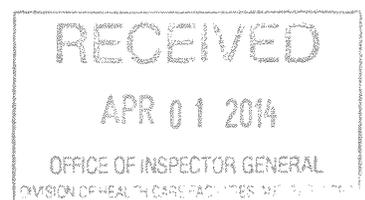
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F 253	<p>Continued From page 2 from the resident's food.</p> <p>Interview with Housekeeper #2, on 02/27/14 at 11:28 AM, revealed she should stop cleaning any time the tray cart came to the floor for meals. She stated housekeeping services should not occur while food was on the floor due to the hazardous risk of spraying chemicals onto resident food. She indicated she had been trained to put the housekeeping cart away during meal.</p> <p>On 02/27/14 at 11:39 AM, interview with Certified Nursing Aide (CNA) #1 revealed housekeeping carts should be removed from the floor during resident meals. She stated with the housekeeping carts and housekeeping services occurring on the floor during meals was a risk of contamination of the food by the cleaning chemicals.</p> <p>Interview, on 02/27/14 at 12:50 PM, with Licensed Practical Nurse (LPN) #1 revealed during meal service all housekeeping carts should be put away, including the floor buffer. The LPN stated housekeeping services should stop during meals and begin again after hall trays had been completed. She indicated cleaning could result in contaminants being airborne and could cross contaminate the residents' food.</p> <p>Interview with Maintenance Technician #1, on 02/27/14 at 2:20 PM, revealed he had replaced ceiling tiles on the floor during a meal service. He stated maintenance services should not occur during resident meals. He indicated maintenance work during meals could be disruptive to residents. Maintenance Technician #1 further indicated having maintenance equipment out during meals could be a risk to residents for a potential to trip and fall.</p>	F 253	<p>If compliance is achieved, one meal per week will be monitored by the Director of Maintenance, Director of Environmental Services, Nurse Unit Manager and Administrator for 4 weeks. If compliance is achieved, each of the 3 daily meals will be monitored monthly by Director of Maintenance, Director of Environmental Services, Nurse Unit Manager and Administrator. The results of all observations will be reported to the Administrator who will report findings to the QA committee monthly.</p> <p>The facility maintains that it has a system of evidencing requested and completed work orders related to maintenance of resident furniture. All defective furniture identified during licensure review was repaired by maintenance staff members on 2/27/14. An audit of all resident furniture was completed by the Administrator with work orders for defective pieces placed by Administrator on 3/18/14. All broken dresser drawers repaired by maintenance technicians on or before 3/26/14.</p>		

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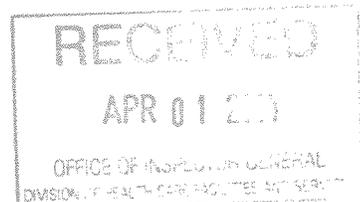
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F 253	Continued From page 3 Interview with Maintenance Technician #2, also on 02/27/14 at 2:20 PM, revealed he replaced a door closure with a cordless powered screwdriver during meal service. He stated maintenance services should not be conducted during meals due to a risk of dust and dirt getting into resident food. On 02/27/14 at 2:33 PM, interview with the Maintenance Coordinator revealed maintenance equipment should not be on the floor during resident meals. He stated maintenance services should not occur during meals as there was a risk of getting dust into the resident's food. The Maintenance Coordinator stated the Maintenance Director monitored the maintenance department and services; however, the Maintenance Director was out of the facility on this day. Interview, on 02/27/14 at 2:54 PM, with the Director of Nursing (DON) revealed housekeeping should be off the unit during resident meal service. She stated a resident could fall over a cord and was a safety issue for housekeeping to work during meals. Additionally, the DON indicated while residents were eating, the time should be relaxing and residents should be allowed to enjoy the meal. She further indicated housekeeping services was noisy and a distraction to the meal. Interview with the Director of Environmental Services (DES), on 02/27/14 at 3:10 PM, revealed when tray carts were on the floor the housekeeping carts should be removed. He stated housekeeping staff was trained to take the housekeeping carts off the floor during meals. The DES indicated he would walk the floor when	F 253	Systematic changes implemented to ensure an effective work order system is sustained include the following: Administrator initiated on 3/24/14 a HCC Work Order Log Book maintained at the nurse unit desk. A Maintenance Technician will review the log book for work orders daily and make necessary repairs. The facility procedure for placing a work order via the log book will be incorporated into the new employee orientation process conducted by the Director of Human Resources for all new employees. All existing staff members received in service education on the HCC Work Order Log Book. In service education completed 3/26/14 by Administrator through written notification. Monitoring steps to ensure that work orders are logged and repairs of broken furniture are made timely include the following: Director of Maintenance or Assistant Director of Maintenance will review the Log Book 2 times per week for 14 days for timely completion of submitted work orders. Maintenance Director or Assistant Director of Maintenance will verify repairs by		



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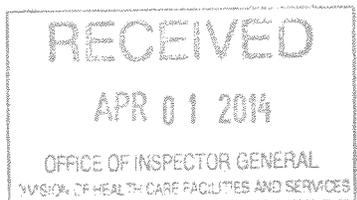
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F 253	<p>Continued From page 4</p> <p>tray carts were out to monitor housekeeping services. He further indicated he completed rounds every two (2) hours; however, did not keep a record of monitoring. The DES stated housekeeping services during resident meals could be a problem for residents who wish to be alone while eating.</p> <p>2. The facility did not provide evidence of work orders requested or completed related to resident dresser drawers.</p> <p>Observation, on 02/26/14 at 8:49 am, 11:59 am, and 3:27 PM, revealed rooms 252, 273A, 273B, 271A, and 279A had broken dresser drawers off track. Additionally, rooms 247B, 267A, 267B, and 269A had a missing handle on the bottom dresser drawer.</p> <p>Interview with LPN #1 revealed any staff at the facility could complete a work order for maintenance of equipment; however, usually the nurse was notified by the Certified Nursing Assistants (CNAs). She stated she had been trained to call work orders and maintenance requests to the reception area; however, she was unaware how the information was then forwarded to the Maintenance Department. The nurse indicated if drawers were broken or had missing handles, then it was possible residents could not get into the drawers for needed items.</p> <p>Interview with Maintenance Technician #1, on 02/27/14 at 2:20 PM, revealed work orders were called into the front desk by facility staff. He stated he was the primary Maintenance Technician responsible to check the front desk for work order requests and completion of the work orders. Maintenance Technician #1 indicated he</p>	F 253	<p>physical inspection. The results of the Maintenance Director's log book review and repairs verification will be reported to the Administrator. If compliance of timely repairs to submitted work orders is achieved, monitoring of the HCC log book will reduce to 1 time per week for the next 30 days and ongoing. The weekly monitoring will be completed by the Director of Maintenance or the Assistant Director of Maintenance. In addition to the monitoring of the log book, Maintenance Technician will audit the unit's furniture weekly for the next 30 days. Maintenance Technician will compare findings of defective furniture against the log book. When the Maintenance Technician identifies the presence of defective furniture not recorded in the log book, findings will be reported to the Administrator for investigation into causes. The results of the monitoring by the Director of Maintenance, Assistant Director of Maintenance, Maintenance Tech and Administrator's investigations will be documented and reported to</p>	



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F 253	Continued From page 5 could not recall any recent work order requests related to dresser drawers for room 252. He further indicated he had worked on the bottom drawer in room 252 two (2) to three (3) weeks ago; however, did not keep a record of completed repairs. On 02/27/14 at 2:33 PM, interview with the Maintenance Coordinator revealed the nurses called the front desk to request a maintenance work order. He stated the Maintenance Director filed the work orders after the orders were completed. The Maintenance Coordinator indicated he could not recall work orders for dresser drawers. He stated if the drawers were not repaired residents could have their fingers pinched or the drawer could fall to the floor. Interview, on 02/27/14 at 2:54 PM, with the DON revealed she had called in maintenance work orders the previous week for dresser drawers and ceiling tiles. She stated she noticed broken drawers during unit rounds; however, did not have record of the rounds or work orders requested. The DON indicated broken drawers were a potential for injury to residents.	F 253	the QA committee by, Maintenance Director and Administrator monthly.		
F 431 SS=D	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.	F 431	F431 This facility maintains that it stores all drugs and biologicals in locked compartments under proper temperature control, and permits only authorized personnel access to the compartments. Potentially all residents could have been but none were affected by this deficient	3/19/14	



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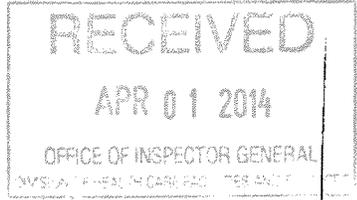
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F 431	<p>Continued From page 6</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to ensure one (1) of two (2) medication carts were locked when not under the direct observation of the Certified Medication Technician (CMT) administering medications during the morning medication pass on 02/26/14.</p> <p>The findings include: Review of the facility's policy titled Storage of Medications (Revised April 2007), revealed</p>	F 431	<p>practice. CMT #1 was counseled immediately upon notification of deficient practice with a review of practice standards pertaining to the storage of drugs and biologicals. All CMT's and licensed nursing staff have been re-educated on the practice standards related to the storage of drugs and biologicals by the Director of Staff Development on 3/19/14. Post-tests were completed by all participants demonstrating knowledge of practice standards. Monitoring steps taken to ensure ongoing compliance with practice standards include: Medication Pass observations will be completed by Licensed Nurse Supervisor, Director of Staff Development-RN, DON, Administrator and Pharmacy Consultant. Each day and on each shift for 14 days, a medication pass observation will occur. If compliance is achieved with daily observations, observations will occur for each shift, two times per week for 2 weeks. Medication Pass observations will be conducted Licensed Nurse Supervisor, Director of Staff Development-RN, DON and Administrator. If compliance is achieved, observations</p>		

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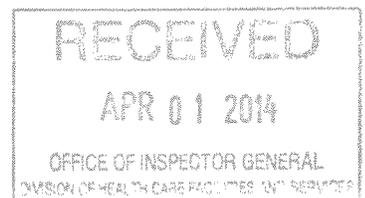
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F 431	<p>Continued From page 7</p> <p>compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use. Trays or carts used to transport such items shall not be left unattended if opened or otherwise potentially available to others.</p> <p>Observation, on 02/26/14 at 8:55 AM, revealed CMT #1 left a medication cart (med cart) in the unit's hallway, unlocked and unattended, while she administered medications to Resident #7, who was in bed #2 (the bed farthest from the doorway of the room). The med cart was stationed just outside the resident's doorway. The unlocked cart was not in the direct view of CMT #1 as she was facing the resident when administering his/her medications. After administering the medication, CMT #1 returned to the med cart to pick up another item for Resident #7 and still did not lock the cart before she returned to Resident #7's bedside.</p> <p>Observation, on 02/26/14 at 9:22 AM, revealed CMT #1's med cart was again left unlocked and unattended in the hallway while she was in Resident #1's room, measuring the resident's vital signs.</p> <p>Observation, on 02/26/14 at 11:35 AM, revealed CMT #1 entered resident Room #246 and left the med cart in the hallway unattended and unlocked.</p> <p>Interview, on 02/26/14 at 2:45 PM with CMT #1, revealed she was instructed by the facility that it was acceptable to leave the med cart unlocked provided the drawer side of the cart was facing toward the room where she would be providing resident care. CMT #1 further stated while she</p>	F 431	<p>will be conducted monthly and will be rotated by shifts, such that each quarter every shift will be observed one time. Observations will be conducted by Licensed Nurse Supervisor, Director of Staff Development-RN and the weekend RN Supervisor. The results of all observations will be documented and turned into DON who will report results to the QA committee monthly.</p>		



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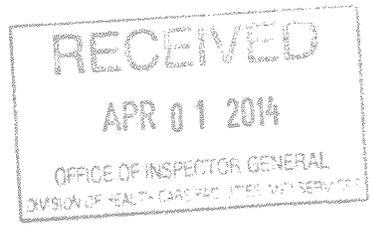
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F 431	Continued From page 8 was watching a resident take his/her medications, she was always looking back at her cart. However, she indicated she was probably not constantly looking at the med cart while administering medications because she would have wanted to make sure the resident took all of his/her medication. CMT #1 further indicated it was not the best practice to leave the med cart unattended and unlocked in the hallway because there was the potential that another resident or visitor could have access to the medications in the cart, and it was not possible for her to keep a constant eye on the unlocked cart while administering medications in the residents' rooms. Interview, on 02/27/14 at 10:50 AM, with Registered Nurse (RN) Supervisor #2 revealed the med cart should be locked unless the CMT or nurse was standing directly beside it. She stated the cart should be locked even if the med cart drawers were facing toward a resident's room. The RN Supervisor #2 indicated the problem with an unattended and unlocked med cart stationed on the unit hallway, would be the potential for residents and visitors to have unauthorized access to the medications in the cart. RN Supervisor #2 revealed the facility's contracted pharmacy staff conducted unannounced med pass observations and in-service education which covered keeping the cart locked when not attended by staff assigned to the med pass. In addition she revealed the Director of Nursing (DON) provided in-service education on keeping the med carts locked when unattended. RN Supervisor #2 stated she monitored the med carts and staff assigned to the carts by conducting daily hallway rounds.	F 431			



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F 431	Continued From page 9 Interview, on 02/27/14 at 2:07 PM, with the DON revealed any time a staff person was beside the med cart or it was not in the staff person's direct view, it should be locked. She stated when a CMT or nurse had his/her back to the cart while administering medications to a resident, the cart should be locked. The DON revealed keeping med carts locked when unattended was addressed during orientation of newly hired nurses and CMTs, and at least annually through in-service education conducted by the facility's staff development personnel. The DON indicated she and the Nurse Supervisor made informal rounds during med pass times to observe whether or not med carts were locked and safely stationed on the units. She revealed if med carts were discovered unlocked during those rounds it would be addressed via on-the-spot re-education of the staff member responsible for the violation.	F 431			
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.	F 441	F441 The facility maintains that it has established a program that controls and prevents the transmission of infections. Sampled resident #3 did not have any negative outcomes related to C.N.A. #1's failure to follow contact isolation precautions. No other residents within the unit were under isolation protocols during the time of the licensure survey. No other residents developed negative outcomes, including newly	3/20/14	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2014	
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F 441	<p>Continued From page 10</p> <p>(b) Preventing 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>(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, and review of the facility's policy, it was determined the facility failed to maintain infection control practice for one (1) of fifteen (15) sampled residents. Resident #3. A Certified Nursing Assistant (CNA) failed to use personal protective equipment (PPE) upon entering Resident #3's room during the lunch meal tray pass; who was also in contact isolation. Additionally, the CNA failed to use appropriate hand hygiene and washed her hands in another resident's room.</p> <p>The findings include: Review of the facility's policy, Handwashing/ Hand Hygiene, revised December 2007, revealed</p>	F 441	<p>diagnosed C-Difficile (C-Diff) infections, related to C.N.A. #1's failure to follow contact isolation precautions. No staff persons have developed negative outcomes related to C.N.A. #1's deficient practice. C.N.A. #1 was counseled immediately upon identification of the deficient practice for retraining and re-education. Since the annual inspection's completion, no other residents have developed conditions warranting contact isolation precautions. All staff members have been re-educated on practice standards which prevent the transmission of infections or diseases including the application and disposal of Personal Protective Equipment (PPE) and Hand Hygiene. In service education with post-tests and return demonstration on hand hygiene completed by Director of Staff Development/Infection Control on 3/19/14. Systematic changes implemented to ensure that the deficient practice does not return include the following measures: Direct care staff members will sign the Change in Condition log book (located at the</p>	

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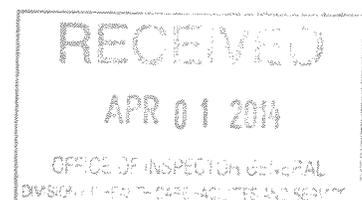
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F 441	<p>Continued From page 11</p> <p>employees must wash their hands before and after direct contact with residents, and when there was a likely exposure to spores such as C. Difficile (C. Diff). Additionally, hand hygiene using an alcohol-based hand rub should be used after contact with objects in the immediate vicinity of the resident. Hand hygiene should be the final step after removing and disposing of PPE.</p> <p>Review of the facility's policy, Standard Precautions, not dated, revealed Contact Precautions would be used for residents who had an infection which could be transmitted by indirect contact, by touching the resident or by touching environmental surfaces or other items in the resident's environment. Gloves and a gown should be worn when entering the room. Gloves should be removed before leaving the resident's room and hands washed immediately.</p> <p>Observation, on 02/26/14 at 12:06 PM, revealed CNA #1 passing lunch trays to resident rooms. CNA #1 entered Resident #3's room, moved the overbed table closer to the resident and assisted with tray set up. CNA #1 was then observed to leave the resident's room with the plate cover and placed the plate cover on the top of the tray cart. CNA #1 then entered the next resident's room and washed her hands. Observation at that time revealed an orange sign posted at Resident #3's door which indicated contact precautions were to be observed and in addition, a PPE cart with gowns and gloves was located by the door.</p> <p>Interview with CNA #1, on 02/27/14 at 11:39 AM, revealed she should have used PPE for Resident #3's tray pass as the resident was in contact isolation. The CNA indicated she was unaware of the reason for Resident #3's contact precautions.</p>	F 441	<p>nurse station) every shift for residents needing isolation precautions acknowledging that they have read and understood the need for isolation and the steps necessary to prevent the transmission of infections or disease. The MDS Coordinator will update the C.N.A. care plan and the resident's care plan upon notification of the status change through the Change in Status Notification process. The following monitoring steps will be implemented to ensure facility compliance with isolation precautions and PPE application/disposal: Observations of C.N.A.'s, C.M.T.'s and licensed nursing personnel will be conducted by: Director of Staff Development, Administrator, DON, Social Services Director and MDS Coordinator. Each day and each shift for 14 days, an observation of direct care staff will occur. If compliance is achieved with daily observations, one observation for each shift will occur weekly for 14 days. If compliance is achieved, one observation for each shift will occur monthly through the individual resident's discharge from isolation</p>		

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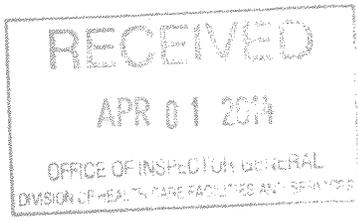
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F 441	<p>Continued From page 12</p> <p>The aide stated she had been trained on the use of PPE and contact precautions. The CNA indicated lunch tray pass was busy and she was trying to get all the trays completed. She stated not wearing PPE and washing hands in another resident's room could lead to cross contamination and transfer the infection to other residents.</p> <p>On 02/27/14 12:50 PM, interview with Licensed Practical Nurse (LPN) #1 revealed Resident #3 was in contact isolation for C. Diff. The LPN stated PPE should be used when entering the resident's room and hands washed with soap and water before leaving the room. She indicated she had been trained on the use of PPE by the facility. The nurse further indicated if PPE was not used and hands were washed in another resident's room there was a risk of cross contamination to other residents.</p> <p>Interview, on 02/27/14 at 2:45 PM, with the Staff Development/ Infection Control Nurse (SD/IC) revealed Resident #3 was in contact isolation for C. Diff. She stated both gown and gloves should have been used prior to entering the resident's room for protection of the staff and residents. The SD/IC indicated hands should be washed with soap and water when entering and leaving the resident's room. She further indicated not using PPE, or washing hands before leaving the resident's room was a risk of cross contamination to others. The nurse stated she had been in the role of the SD/IC for about a month. She indicated staff were trained on hand hygiene during orientation and she had conducted an informal training recently; however, did not remember when the training occurred.</p> <p>On 02/27/14 at 2:54 PM, interview with the</p>	F 441	<p>precautions by physician order. The results of all observations will be documented and reported to the DON will report monthly to the QA committee.</p>		



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F 441	Continued From page 13 Director of Nursing (DON) revealed PPE should have been worn before entering Resident #3's room for tray pass as the resident was in contact isolation. She stated the aide should have also washed her hands when entering and before leaving the resident's room. The DON indicated there was a risk of contamination and spread of infection if these things were not done. She further indicated a hand washing inservice had been conducted by the SD/IC on 02/20/14 with return demonstration. The DON stated she completed random unit inspections and hand hygiene inspections; however, she did not keep a record of the unit inspections.	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1983</p> <p>Survey under: 2000 existing</p> <p>Facility type: S/NF DP on the second floor of a Health Care facility.</p> <p>Type of structure: Eleven (11) stories, Type II protected construction.</p> <p>Smoke Compartment: Six (6) smoke compartments on the second floor skilled nursing unit.</p> <p>Fire Alarm: Complete fire alarm system with heat and smoke detectors.</p> <p>Sprinkler System: Complete automatic (wet) sprinkler system, hydraulically designed.</p> <p>Generator: Type II, 275 KW generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/26/14. The skilled nursing facility located on the second floor of Treyton Oak Towers was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x William Wideman</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>4-1-14</i>
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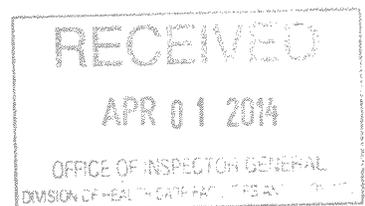
any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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K 000	Continued From page 1 Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		
K 046 SS=F	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide testing of emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the (6) smoke compartments on the second floor, residents, staff and visitors. The facility has sixty (60) certified beds and the census was fifty-one (51) on the day of the survey. The findings include: Record review, on 02/26/14 at 9:01 AM, with the Director of Plant Operations and the Maintenance Assistant revealed the facility failed to conduct annual tests on all of the battery-powered emergency light fixtures within the facility, for 1-1/2 hours of continuous illumination. The facility tested each of the battery-powered emergency light fixtures for ten (10) to fifteen (15) minutes each month to accumulate a minimum of 1-1/2 hours annually, instead of being illuminated for a continuous 1-1/2 hour test. Interview, on 02/26/14 at 9:01 AM, with the	K 046	The facility maintains that all battery-powered emergency light fixtures within the facility were tested for 1-1/2 hours over the course of a year. Beginning March, 2014, the Assistant Director of Maintenance will implement a schedule in which all battery-powered emergency light fixtures within the facility are tested for 1-1/2 hours of continuous operation annually. Testing of emergency light fixtures will be completed according to protocol which includes the turning off of the power source to the light fixture which causes the emergency power source for the lighting to come on. The Assistant Director of Maintenance will document the testing of all battery-powered emergency light fixtures	3/31/14



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K 046	<p>Continued From page 2</p> <p>Director of Plant Operations and the Maintenance Assistant revealed they were not aware of the battery-powered emergency light fixtures requirement to be tested annually for 1-1/2 hours of continuous illumination.</p> <p>Interview, on 02/26/14 at 1:22 PM, with the Administrator revealed he had been employed as the new Administrator for two (2) weeks and was not aware of the requirement for battery-powered emergency light fixtures to be tested annually for 1-1/2 hours of continuous illumination.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of</p>	K 046	<p>for 1-1/2 hours continuous operation annually on departmental log sheet. The Director of Maintenance will monitor the Assistant Director of Maintenance's status with respect to testing all battery-powered emergency light fixtures by reviewing log documentation. The Director of Maintenance will report findings of documentation reviews to the QA committee quarterly for review.</p>	

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K 056	<p>Continued From page 4 certified beds and the census was fifty-one (51) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/26/14 at 10:04 AM, with the Director of Plant Operations and the Maintenance Assistant revealed the storage closet located in Resident Room 252, was not protected by automatic sprinkler coverage.</p> <p>Interview, on 02/26/14 at 10:04 AM, with the Director of Plant Operations and the Maintenance Assistant revealed they were not aware of the storage closet not being protected by automatic sprinkler coverage. The room had previously been used for Staff before being converted to a private resident room.</p> <p>Interview, on 02/26/14 at 1:22 PM, with the Administrator revealed he had been employed as the new Administrator for two (2) weeks and was aware of the requirement for complete sprinkler coverage for all parts of the building, but was not aware of the storage closet in Resident Room 252 not being protected by automatic sprinkler coverage.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the</p>	K 056	<p>be documented on the environmental rounds log sheet and the results of the rounds will be reported to the Director of Maintenance. The Director of Maintenance will report findings to the QA committee quarterly.</p>		

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K 056	Continued From page 5 Installation of Sprinkler Systems. Reference: NFPA 13 (1999 Edition) 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056			
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments on the second floor, residents, staff and visitors. The facility has sixty (60) certified beds and the census was fifty-one (51) on the day of the survey. The facility failed to ensure escutcheon plates were installed at all sprinkler heads. The findings Include: Observations, on 02/26/14 between 10:12 AM	K 062	K062 The facility maintains that it has an automatic sprinkler system that is continuously maintained in reliable operating condition. All rooms and storage closets within the facility were inspected for the presence of intact sprinkler heads including escutcheon plates and except for the two identified as missing, all plates were present. Midwest Sprinkler Company installed escutcheon plates on 3/4/14. Monitoring for the presence of escutcheon plates in all rooms of the facility, including storage closets, will occur monthly through environmental rounds by maintenance technician.	3/4/14.	

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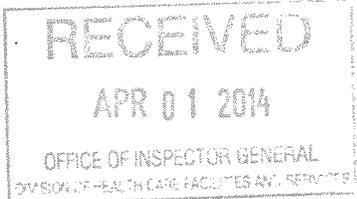
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 6</p> <p>and 10:52 AM, with the Director of Plant Operations and the Maintenance Assistant revealed there were escutcheon plates missing at two (2) sprinkler heads located in the storage closet in Resident Room 244 and in the closet located in the Dentist Office.</p> <p>Interview, on 02/26/14 between 10:12 AM and 10:52 AM, with the Director of Plant Operations and the Maintenance Assistant revealed they were unaware of the escutcheon plates missing at the sprinkler heads.</p> <p>Interview, on 02/26/14 at 1:22 PM, with the Administrator revealed he had been employed as the new Administrator for two (2) weeks and was not aware of the escutcheon plates missing at the two (2) sprinkler heads.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the</p>	K 062	<p>The presence of escutcheon plates will be documented on the environmental rounds log sheet with results reported to the Director of Maintenance. The Director of Maintenance will report findings of the environmental rounds to the QA committee quarterly.</p>	

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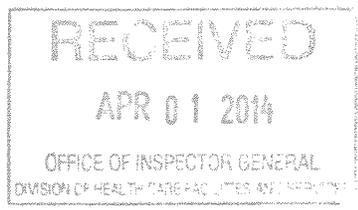
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K 062	Continued From page 7 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring and devices were maintained in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of	K 147	K147 The facility maintains that it maintains electrical wiring and equipment in accordance with NFPA 70, National Electrical Code. The identified electrical panel had the potential for affecting the residents within the particular smoke compartment of the facility. No residents were affected by the electrical panel identified as lacking	3/18/14



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K 147	<p>Continued From page 8</p> <p>six (6) smoke compartments on the second floor, residents, staff, and visitors. The facility has sixty (60) certified beds and the census was fifty-one (51) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/26/14 at 11:02 AM, with the Director of Plant Operations and the Maintenance Assistant revealed an electrical panel located within Resident Room 235 was unlocked and permitted unauthorized access to electrical circuits. The panel directory was not labeled to identify the locations of the circuit power distribution.</p> <p>Interview, on 02/26/14 at 11:02 AM, with the Director of Plant Operations and the Maintenance Assistant revealed they were not aware of the requirement that electrical panels, located in the resident accessible areas, were to be locked and panel directories to be labeled.</p> <p>Interview, on 02/26/14 at 1:22 PM, with the Administrator revealed he had been employed as the new Administrator and was not aware of the electrical panel located in Resident Room 235 not being lockable and the panel directory not being labeled.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical</p>	K 147	<p>the secured cover and labeling. An audit of the facility's electrical panels resulted in the location of an additional panel in the therapy gym that was not secured according to NFPA 70, National Electrical Code. Custom made panel covers with locks were purchased and were installed on both electrical panels on 3/17/14 by the Director of Maintenance. The labeling of the electrical circuits in the panel located within room 235 was completed by the Assistant Director of Maintenance on 3/4/14. Electrical panels will be monitored by the Maintenance Technician for the presence of locked covers and labeling of all circuitry. The presence of both locked panels and labeled circuitry will be logged on the monthly environmental rounds tracking system. The Director of Maintenance will report the results of the environmental rounds monitoring to the QA committee quarterly.</p>	



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K 147	Continued From page 9 apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147			

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