

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

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PRINTED: 07/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185225</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/19/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ROSEDALE GREEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4250 GLENN AVENUE COVINGTON, KY 41015</b>
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(X4) ID PREFIX TAG	SUMMARY OF STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<b>PLAN OF CORRECTION:</b> The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	8/3/2015
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A Recertification Survey was initiated on 06/16/15 and concluded on 06/19/15. Deficiencies were cited with the highest scope and severity of a "F".  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  Rosedale Green is committed to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinic complications); a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).	8/3/2015

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sandra Knollman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/17/15</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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable after 90 days following the date of the 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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F157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Physician was immediately notified when there was a significant change in the resident's physical status for two (2) of twenty-nine (29) sampled residents.</p> <p>Resident #16 was being treated for Clostridium Difficile (C. Diff) and review of bowel records revealed the resident had formed stools; however, when episodes of loose watery stools re-occurred the facility failed to inform the physician of the change in stool status.</p> <p>Resident #6's 06/07/15 weight was flagged as out range by the facility's computer system and when the weight of 163 pounds was compared to prior weights there was significant weight loss; however, the facility failed to notify the resident's Physician of the weight change.</p> <p>The findings include:</p> <p>Review of the facility's policy: "Change of Resident Condition, Family and Physician Notification", revised date 03/02/13, revealed it was the expectation the Physician was notified, as soon as feasibly possible, regarding any significant change in the resident's physical status regardless of code status. Further policy review revealed the notification of the Physician should be documented in the medical record.</p> <p>1. Observation on 06/16/15 at 10:45 AM of Resident #16 in his/her room, revealed a sign on</p>	F157	<p>Rosedale Green's policy and procedure "Change of Resident Condition" was reviewed by the Director of Nursing on 6/22/15 and was determined to remain appropriate.</p>	

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F157	<p>7: Continued From page 2</p> <p>the door which stated "Listed Infections and Conditions Requiring Contact Precautions". Interview with Certified Nurse Aide (CNA) #10, at the same time as the observation revealed the sign may be with relationship to contact precautions; however, she was not aware if Resident #16 was considered to have contact precautions.</p> <p>Review of the clinical record for Resident #16 revealed on 06/09/15, the facility readmitted the resident with diagnoses which included Urinary Incontinence, C-Diff, Diarrhea and Debility. There was no documented evidence that the physician was notified when resident's symptoms returned for possible C-Diff; however, additional review of the resident's June 2015 Vitals Report dated 06/17/15 for Bowel Movements, revealed the resident had stool episodes on 06/12/15 at 7:15 AM listed as "Continent Loose Consistency"; 06/12/15 at 11:50 AM listed as "Continent Loose Consistency"; 06/15/15 at 5:52 PM listed as "Continent Loose Consistency"; and 06/16/15 at 4:22 PM listed as "Incontinent Loose-Liquid Consistency".</p> <p>Interview, on 06/16/15 at 4:52 PM, with CNA #12 revealed she was not sure if the resident was under contact precautions. She further stated she had not worn a protective gown when she assisted the resident to the toilet. She stated she just informed Resident #16 had C-Diff on 06/16/15.</p> <p>Interview, on 06/16/15 at 4:58 PM, with Nurse Manager #4 revealed Resident #16 did not actively have diarrhea but was under contact precautions. She stated the nurse managers put contact precautions on the door and were</p>	F157	<p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #10 not only through report during the shift change huddle, but also via the Point of Care (POC) electronic documentation system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #10, reflected that this resident was under contact precautions.</p> <p>With regards to Resident #16, upon readmission to the facility on 6/9/15, the hospital had discontinued her treatment with Flagyl. However, due to her history, the facility physician ordered Flagyl 250mg bid x 10 days then Flagyl 250 mg x 10 days for loose stools as a precautionary measure. From the most recent admission to Rosedale Green on 5/21/15, this resident has been treated for C-Diff and has had varying consistencies and frequencies of her bowel movements, including continent and incontinent episodes. The physician was contacted on 6/19/15 by the charge nurse and verbalized he did not consider her loose stools, a change in condition and ordered a stool test for C-Diff. Although the resident continued to have loose stools, the result on 6/21/15 was negative for C-Diff. The physician was notified of the negative results, and ordered to continue with the current treatment orders until finished.</p> <p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #12 not only through report during the shift change huddle, but also via the POC system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #12, reflected that this resident was under contact precautions.</p>	
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F157	<p>Continued From page 3</p> <p>expected to notify staff in the "huddle room" of the resident's condition. She stated the resident was not actively infected with C-Diff but was still taking Flagyl.</p> <p>Interview, on 06/16/15 at 5:13 PM, with the Assistant Director of Nursing (ADON), who also served as the Infection Control Nurse, revealed the resident was admitted to the facility with active C-Diff. She stated the resident was put on contact precautions and all staff was notified in the facility "Huddle" meeting. She stated Resident #16 no longer needed contact precautions, but standard precautions, because he/she had no active episodes of diarrhea. She stated the resident's use of Flagyl, required regular standard precautions.</p> <p>Further interview, on 06/17/15 at 5:41 PM, with the ADON, revealed she had not been made aware that the resident's symptoms had returned. She stated the facility's process was to notify the physician to continue with contact precautions. She stated based on the observed Vitals Report for Bowel Movements the resident may still have C-Diff. She stated the facility failed in its process to notify her and the physician when the symptoms of C-Diff returned for Resident #16. She concluded the concern for the resident and the other resident's for failure to notify the physician and for failure to follow the facility's process, was the possibility of infection due to contact of C-Diff and improper contact precautions.</p> <p>Interview, on 06/17/15 at 6:13 PM, with the Director of Nursing (DON) revealed the facility failed to notify the physician of Resident #16's returned symptoms for C-Diff. She stated facility</p>	F157	<p>All nursing staff will receive additional training by 7/31/15 reminding them that they are to refer to the POC system to determine specific care needs of each resident each shift. This training will be completed by the, ADON, staff educator, nurse manager, MDS / RAI nurse, or nursing supervisor</p> <p>All facility staff will be inserviced as of 7/31/15, regarding the infection control protocol required when providing care for a resident that requires more than Standard Precautions. This includes a sign placed on the residents door that reads "Please See Nurse Before Entering". The nurse will then give them additional information regarding infection control procedures. If at any time they are unclear as to why the sign is in place, they are expected to see the nurse before entering. This training will be conducted by their department director, department supervisor, ADON, staff educator, nurse manager, or MDS / RAI nurse</p> <p>All nurses will receive additional training regarding the notification of physicians when the resident has experienced a change in condition. This training will be conducted by the ADON, staff educator, nurse manager, MDS / RAI nurse, or nursing supervisor.</p>	

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F157	<p>Continued From page 4</p> <p>staff should have reported when changes occurred for the resident and the nurses should have asked questions with regard to the Vitals Report for Bowel Movements upon review. She stated it was her expectation that the resident receive additional testing at the point of returned symptoms and this would possibly occur through notification to the resident's primary care physician. The Charge Nurse, Nurse Manager and the MDS Nurse should have been aware that the resident's symptoms had returned and the nurse should have notified the physician. She stated it was her expectation that the facility nurses notify the physician once they became aware of the resident's recurring symptoms.</p> <p>2. Review of the facility's policy: "Weight Changes", revised date 11/11/13, revealed changes in weight were monitored, addressed, and communicated to the physician. The policy noted weights were done at least monthly and the last weight was compared to prior weights to determine progressive weight changes. Further review of the policy revealed the facility defined significant weight loss as a 5% change in one (1) month, a 7.5% change in three (3) months, and a 10% change in six (6) months.</p> <p>Review of the medical record revealed Resident #6 was admitted by the facility on 06/21/11 with diagnoses which included Anemia, Debility, Alzheimer's Disease, Diabetes, Chronic Kidney Disease, Chronic Heart Failure, and Right Side Hemiplegia (Weakness of the entire right side of the body). The medical record noted the resident was palliative care, 04/24/15, with no aggressive treatment per family wishes. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/05/15, revealed the facility assessed the</p>	F157	<p>Rosedale Green's policy "Weight Changes" was reviewed on 6/22/15 by the Director of Nursing and was determined to remain appropriate.</p> <p>With regards to resident #6, following an interdisciplinary team meeting with his family, his care needs were changed to palliative on 4/23/15. His plan of care was updated to reflect this change.</p>	
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F157	<p>Continued From page 5</p> <p>resident as severely cognitively impaired. Resident #6's comprehensive care plan revealed the resident was a significant weight loss risk and had a nutrition care plan developed which included monthly weights.</p> <p>Record review of Resident #6's vitals report of weights revealed on 06/07/15 the resident's weight was 163 pounds and was flagged, by the system, because the percent weight change in thirty (30) days was not in the acceptable range. Further review of the weights revealed the prior weight, recorded 05/20/15, was 174 pounds, and the percentage difference of 6.3% was a significant weight loss, per the facility's definition. In addition, there was a three (3) month significant weight loss of 11.9% (03/01/15 weight was 185 pounds) and a six (6) month significant weight loss of 17.7% (12/13/14 weight was 198 pounds).</p> <p>Further medical record review of resident progress notes revealed no documentation the Physician or the facility's Dietician were notified of the significant weight loss.</p> <p>Interview, on 06/18/15 at 1:09 PM, with Certified Nursing Assistant (CNA) #13 and at 06/19/15 at 4:47 PM with CNA #14 revealed residents were weighed at least monthly and entered into the system by CNA's. CNA #13 and #14 revealed resident weights were entered into the system and they were to notify nursing the if the weight was flagged as out of range.</p> <p>Interview, on 06/18/15 at 1:08 PM, with Licensed Practical Nurse (LPN) #4 revealed the CNAs notified the nurse if the system flagged a weight as being out of range and the floor nurse notified</p>	F157	<p>All residents are weighed monthly, unless otherwise requested by the interdisciplinary team. The dietician reviews these weights entered into the medical record each month.</p> <p>The dietician was notified of resident # 6's new weight changes on 6/18/15. At that time, the dietician made the following recommendation: "d/c routine monthly wts as loss continues despite supplementation/interventions and further wt loss may be unavoidable given dx/POC- notified nurse to f/u with MD/family. Staff to encourage snacks/fluids throughout the day and work with IDT to maximize comfort". The physician was notified and an order was obtained to d/c monthly weights due to expected decline, but weights continue to be obtained due to family wishes.</p> <p>With regards to CNA #13 and #14; LPN #4; RN #4; and the dietician, they were all aware and accurately reflected our policy on weights.</p> <p>Any resident with a change in condition, including weight loss, has the potential to be affected if this policy is not followed. Therefore, all staff who report changes in condition to the physician or dietician will be inserviced by 7/31/15. These inservices will be given by the Nurse Managers, ADON, MDS/RAI nurse, staff development and Nursing Supervisors and include the expectation that staff monitor for and notify the physician and dietician when an appropriate change in condition has been identified.</p>	

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F157	<p>Continued From page 6</p> <p>the Unit Manger of the out of range weight.</p> <p>Interview, on 06/19/15 at 5:00 PM, with LPN #4 revealed if the resident's weight was out of range they were supposed to notify the Dietician and Physician to determine if interventions were needed. LPN #4 revealed they documented the Physician was notified regarding the weight change.</p> <p>Interview, on 06/19/15 at 4:24 PM, with Registered Nurse (RN) #4/Unit Manager (UM) revealed if the resident's entered weight was out of range, a weight change of 4% or more from the prior weight, it flagged in the system and the CNA notified the nurse. RN #4/UM revealed the facility's process was not followed because the physician was not notified Resident #6's weight change. Further interview revealed it was important to notify the Physician because of the impact on the resident's nutrition and the the opportunity of a treatment change.</p> <p>Interview, on 06/19/15 at 10:30 AM, with the facility's Dietician revealed based on the 06/07/15 weight of 163 pounds, Resident #6 had significant weight loss compared to prior weights at intervals of one (1) month, three (3) months, and six (6) months. The Dietician revealed nursing was supposed to notify the Dietician and Physician of significant weight loss.</p> <p>Interview on 06/19/15 at 5:13 PM, with the Director of Nursing (DON) revealed the system was not followed because when the out of range weight was identified the Physician and Dietician were not notified to determine possible interventions.</p>	F157	<p>Monitoring of physician and dietitian notification of changes will be completed daily by reviewing facility activity reports to identify pertinent changes. Audits will be completed each week by the neighborhood nurse manager or ADON. All audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p> <p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/3/15 and will continue weekly for 4 weeks. The audits will monthly for 6 months.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning notification of changes will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The DON is responsible to ensure compliance with notification of changes. This topic will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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F252 SS=D	<p>2) Continued From page 7</p> <p>2) 483.15(h)(1)</p> <p>1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure a safe, clean and comfortable environment. Observation of the shower rooms on the 2nd floor revealed cracked flooring, cracked tile in the corners of the shower stall, safety strips missing on the floor, lime build up on the faucets, and leaking pipes behind the whirlpool. In addition, the whirlpool would not turn on from the tub and there was lime on the faucet in the shower. Furthermore, during tour rooms 209 and 228 had lime build up around faucets.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Bath room Cleaning and Raised Toilet Seats" revised 02/12/13, revealed it was the facility's policy to provide proper care and cleaning to bath rooms. Continued review revealed, the proper methods and procedures for cleaning bathrooms were necessary to prevent the spread of harmful bacteria. Further review of the policy revealed staff should provide a One-Step disinfectant that should be left on clean surfaces and allowed to air dry for at least ten (10) minutes. Additionally, it was the policy to wash the basin and pipe under</p>	F252	<p>Rosedale Green is committed to providing a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>The policy and procedure "Bath Room Cleaning and Raised Toilet Seats" was reviewed by the Director of Housekeeping on 6/19/2015 and was determined to remain appropriate.</p>	8/3/2015

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F252	<p>2. Continued From page 8 the wash basin.</p> <p>Review of the facility's policy titled, "Work Orders, Maintenance", dated 10/01/2008, revealed maintenance work orders would be completed in order to establish a priority of maintenance service. Continued review of the policy revealed in order to establish a priority of maintenance service, work orders must be completed and reviewed by the maintenance department. It would be the responsibility of each staff member to fill out work orders when an area of concern was noted. A supply of work orders would be maintained in each neighborhood, dietary department, front office, laundry, and the therapy department. The Director of Maintenance would assign maintenance staff to pick up, review, and complete the work orders on a daily basis. Work orders that were not completed immediately would remain in the work order book (yellow copy) until the replacement part had arrived, or the necessary repair was completed. Additional review of the Facility's Policy revealed the Director of Maintenance was responsible for this policy.</p> <p>Observation of the shower rooms on the second floor on the initial tour of the facility, on 06/16/15 revealed cracked flooring, cracked tile in the corners of the shower stall, safety strips missing from the floor, lime build up on the faucets, leaking pipes behind the whirlpool, and a lime build up was noted on a faucet in the shower room. Furthermore, during tour observations on 06/16/15, rooms 209 and 228 had lime build up around faucets in those rooms. Observation on the first floor on unit one (1) revealed two tiles with cracked corners in the second shower in the Women's shower room and a sharp piece of material on the floor board sticking out of the</p>	F252	<p>The policy and procedure "Work Orders, Maintenance" was reviewed by the Environmental Services Director on 6/19/2015 and was determined to remain appropriate.</p> <p>The Whirlpool Tub Vendor and Environmental Services Director assessed the whirlpool "leaking pipes" and determined that while there was water on the floor surface and a noise that sounded like water coming through the pipes it was really a noise being made by an internal solenoid. This part has been ordered and the whirlpool taken out of service as a precautionary measure until a new solenoid is installed. The water observed in the floor on 6/16/15 was immediately mopped by the housekeeping staff. An audit was completed by the Facility Environmental Services Director by 7/17/15 on all whirlpool tubs to ensure they were functioning properly without any concerns.</p> <p>All facility staff will receive additional training on the facility "work order" policy, specifically the importance of completing work orders when equipment or the facility environment is noted to have concerns. Staff will receive this training from their department director, department supervisor, ADON, staff educator, nurse manager, or MDS / RAI nurse by 7/31/2015.</p> <p>The lime build up on the faucets of the shower rooms on the second floor and in rooms 209 and 228 were addressed by the housekeeping supervisor prior to 6/19/2015. An audit will be conducted by the housekeeping supervisor identifying the condition of all faucets in the resident rooms and shower rooms by 7/31/2014.</p>	
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NAME OF PROVIDER OR SUPPLIER  ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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F252	<p>Continued From page 9</p> <p>entrance to the second shower of the Men's shower room.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 06/16/15 at 6:10 PM, revealed the one piece of the safety strip from the facility's second floor men's shower room, located on Autumn Woods, was missing. She reported all of the strips should have been pulled up and replaced, continued observation revealed a cracked tile on the corner of the shower stall. CNA #1 reported this was a safety concern because a resident could have a skin tear related to getting to close to the cracked tile. CNA #1 stated the safety strips were important so residents would not slip while in the shower. Continued interview with CNA #1 revealed there was a hole/dent in the flooring of the shower room. She reported she would normally put a towel over the hole to keep residents from falling. Additional interview with CNA #1 revealed a work request would be filled out for repairs if she noticed concerns with needed repairs throughout the facility, but added she did not fill out a maintenance request for the concerns noted within the bathroom. CNA #1 reported that based on her observation of the bathroom, it was not a "homelike" environment for the residents.</p> <p>Interview with CNA #3, on 06/17/15 at 9:55 AM, located in the women's bathroom of Willow Glen, revealed that while demonstrating to other "CNA's in training" on the procedure for cleaning the whirlpool, she was observed to go behind the whirlpool, using the valve near the pipes, to turn on the water. She reported she had done this for over three (3) years and was told by previous staff to turn the water on from the back of the tub. Further interview with CNA #3 revealed a</p>	F252	<p>All homemaking staff will receive in-service on procedures to follow for properly de-liming faucets to prevent build up of lime deposits. These in-services will be conducted by the Housekeeping Supervisor and completed by 7/31/2015.</p> <p>The maintenance department replaced the cracked tiles on the corners of the shower stalls and then installed stainless steel corner strips to prevent additional cracking if hit by equipment, wheelchairs, etc. in the future. This was completed by 7/15/2015.</p> <p>All shower room flooring and safety strips identified during the survey observations on 6/16 - 6/19 were repaired and/or installed by the maintenance staff prior to 7/15/2015.</p> <p>The sharp piece of material on the floor board sticking out of the entrance to the second shower room of the Men's shower room on 6/16/15 was corrected on 6/16/15 by the Environmental Services Director.</p> <p>An audit of all the shower rooms was completed prior to 7/17/2015 by the maintenance department to identify any additional areas in need repair, including but not limited to tile, flooring, safety strips.</p> <p>Monitoring of the shower rooms, including lime build up, safety strips, cracked tile, leaking pipes and other environmental concerns will be completed daily by the homemakers. The Housekeeping Supervisor will complete audits of each shower room (8 total) on a weekly basis for the next 3 months beginning 8/3/2015. If no trends are identified, the audits will then be completed on a monthly basis. The Housekeeping Supervisor will also conduct audits of resident rooms on a weekly basis, auditing 2 resident rooms on each hall way (24 total) weekly for the next 3 months beginning 8/3/2015, if no trends identified the audits will be conducted monthly.</p>	
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F252	<p>Continued From page 10</p> <p>maintenance request should have been completed adding, "this did not create a homelike environment for the residents".</p> <p>Interview with Unit Manager #4, on 06/18/15 at 12:00 PM, located on Magnolia Springs, revealed she considered the two (2) cracked tiles outside the shower in the Women's Shower Room to be a hazard to the residents. She reported the cracked tile could result in a skin tear. Unit Manager #4 then placed a chair in front of cracked tiles to ensure the residents would not be injured. Further interview with Unit Manager #4 revealed the sharp piece sticking outside the shower room could result in a skin tear or a fall, adding it was not homelike or safe for the residents.</p> <p>Interview with Housemaker #3, on 06/17/15 at 11:40 AM, revealed housekeeping was responsible for cleaning the scaling around the faucet in the bathrooms, adding it was a part of their daily cleaning schedule. Continued interview with Housemaker #3 revealed she did not know how long it took for the scaling to build up, but added it was important it was cleaned because, "it did not look good" and "it did not create a homelike environment for the residents".</p> <p>Interview with the Housemaker Manager, on 06/17/15 at approximately 12:30 PM, revealed it would be her expectation that staff would clean the faucets everyday and if they need other chemicals to clean the "scaling" off of the faucets, she would provide it to them. She reported she has asked her staff to check all of the residents' rooms and the shower rooms for "scaling" of the faucets. Continued interview with the Housemaker Manager revealed it did not create a</p>	F252	<p>The Housekeeping Supervisor will provide the Director of Housekeeping and the Director of Environmental Services a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning the physical environment, specifically the shower rooms and resident bathrooms will be reviewed at the regular QA/PI meetings, and as necessary, at any subsequent special meetings called during the review period to ensure ongoing compliance.</p> <p>The Director of Housekeeping and Environmental Services is responsible for ensuring compliance with a safe, clean, comfortable homelike environment.</p>	
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F252	<p>2 Continued From page 11 homelike environment for the residents.</p> <p>Interview with Director of Maintenance, on 06/17/15 at 10:05 AM, revealed while in Willow Glen's women's shower/bathroom, it had been awhile since the shower floor fall strips had been taken up and replaced. He reported the broken tile outside of the shower must have occurred when a wheelchair ran over it, but would expect staff to report the broken tile to him if there were any areas in the shower that needed to be repaired. Continued interview with the Maintenance Director revealed he was not certain how long the whirlpool, located on Willow Glen, was "leaking" water in the back of the whirlpool, but reported it had been awhile and he was looking for a piece to replace it. He reported he had to replace the lines on the whirlpools for both Willow Glen, women's bathroom, and Autumn Woods, women's bathroom. Further interview with the Maintenance Director revealed staff should complete work order books, which were located at all Nursing stations and that someone from maintenance checked the books several times a day for work requests. Additionally, he reported he would expect staff to notify him for problems concerning maintenance. He stated he should have been notified of all maintenance concerns. The Maintenance Director reported housekeeping was responsible for the cleaning of the lime buildup around the faucets. He reported he would want the bathrooms to be homelike for his family, so he would expect the same for the residents.</p> <p>Interview with Director of Nursing (DON), on 06/19/15 at 1:35 PM, revealed that plumbing with leaking water, scaling on the bathroom faucets, and other facility maintenance/housekeeping</p>	F252		

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F252	Continued From page 12 concerns was not a homelike environment for the residents. She reported anyone could fill out a maintenance request at the nurses station; however, she was unsure how frequently maintenance checked the work order book. The DON reported it would have been her expectation of staff that they would fill out work requests when a problem was noted.  Interview with the Administrator, on 06/19/15 at 5:45 PM, revealed it would be her expectation that staff would fill out work orders when they noticed maintenance was required. She reported this was important for the safety and cleanness of the residents.	F252		
F280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F280	483.20(d)(3), 483.10(K)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  Rosedale Green is committed to developing a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.	8/3/2015

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F280	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of twenty-nine (29) sampled residents (Resident #26).</li> <li>Resident #26's Care Plan was not revised related to contact precautions and Clostridium Difficile (C-Diff) (a very contagious bacterial organism that causes an infection of the intestinal tract).</li> </ul> <p>The findings include:</p> <ul style="list-style-type: none"> <li>Review of Resident #26's clinical record revealed the facility admitted the resident on 05/30/15 and re-admitted the resident on 06/13/15 with diagnoses which included Debility and Osteoarthritis. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/15/15, revealed the facility assessed Resident #26 as having a Brief Interview for Mental Status of a eight (8) out of fifteen (15) indicating cognitive impairment.</li> <li>Review of the Resident Progress Notes dated 06/16/15, at 8:17 PM, revealed Resident #26 had foul smelling loose bowel movement (BM), the Physician was notified and orders were received to send a stool to the lab to test for Clostridium Difficile (C-Diff) (a very contagious bacterial organism that causes an infection of the intestinal tract).</li> </ul>	F280	<p>From the most recent admission to Rosedale Green on 5/21/15, Resident #26 has been treated for C-Diff and has had varying consistencies and frequencies of her bowel movements, including continent and incontinent episodes.</p>	
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F280	<p>Continued From page 14</p> <p>Review of the laboratory data revealed the stool specimen was collected on 06/17/15 and was reported on 06/17/15 as C. Diff positive.</p> <p>Further review of the Resident Progress Notes, dated 06/17/15 at 5:36 PM, revealed Resident #26 had positive results for C-Diff, and a message was left for the Physician. Review of the Notes dated 06/17/15 at 6:38 PM, revealed a message was received from the Physician related to the positive C-Diff results with new orders received for Flagyl 500 milligrams (mg) three (3) times a day for ten (10) days (antibiotic medication), Florastor 250 mg two (2) times a day for ten (10) days (probiotic) and contact isolation until loose stool resolves.</p> <p>Review of Resident #26's Physician's Orders, dated 06/17/15, revealed orders for Flagyl 500 mg three (3) times a day for C-Diff, and Florastor 250 mg two (2) times a day for C-Diff.</p> <p>Review of the Comprehensive Plan of Care, dated 06/01/15, revealed no documented evidence the Care Plan was revised related to the diagnosis of C-Diff and the need for contact isolation precautions.</p> <p>Observation, on 06/18/15 at 5:10 PM, revealed there was no signage on the resident's door to alert staff, family, and visitors of the need to see the nurse before entering the room. In addition, there was no personal protective equipment (gloves, gowns) outside the resident's door accessible for use.</p> <p>Interview with Certified Nursing Assistant (CNA) #14, on 06/18/15 at 5:10 PM, revealed she had been assigned to Resident #26 since 7:00 AM</p>	F280	<p>With regards to Resident #26, the plan of care was reviewed and updated on 6/17/15 to reflect the diagnosis of C-Diff. The plan of care was, again, reviewed and updated to reflect contact precautions on 6/18/15 by the MDS nurse as the official positive lab report was received on 6/17/15 at 5:20 pm.</p> <p>A sign stating "See Nurse Before Entering" was placed on the door by the Nurse Manager on 6/18/15. Personal Protective equipment was available at all times in the nurse's nook and was accessible for use.</p> <p>On 6/18/15 the MDS nurse for Resident #26 was inserviced by the DON on the need to update the plan of care to reflect contact precautions for C-Diff and other MDRO's.</p> <p>All residents requiring contact precautions have the potential to be affected. On 6/18/15, an audit was completed by the Neighborhood Nurse Managers to ensure all residents with C-Diff and MDRO had signs placed on their doors stating "Please See Nurse Before Entering". On 6/18/15 and 6/19/15, the MDS nurses reviewed the care plans for all residents with C-Diff and / or MDRO if needed, the care plan was updated to reflect the need for contact precautions.</p>	

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F280	<p>Continued From page 15</p> <p>that morning. She stated she was aware the resident had C-Diff and was in contact isolation and she was to use contact precautions, although there was no signage on the resident's door. Continued interview revealed after reviewing the CNA Care Plan, there was no contact precautions noted to alert the CNA's. She stated she knew the resident had C-Diff from the morning report which she received from the nurse and also she received report from the CNA who was going off duty.</p> <p>Interview, on 06/18/15 at 5:25 PM, with Registered Nurse (RN) #2, revealed she was assigned to Resident #26 and was aware the resident was on contact isolation precautions for C-Diff. She stated Resident #26 was receiving Flagyl (antibiotic medication) and the staff was to wear gloves when caring for the resident as well as gowns if the resident had explosive diarrhea or if there was a large amount of stool and staff would also need to wear a gown to make the bed and change bed linens. Further interview revealed there should be signage on the door stating "see nurse before entering" to alert visitors, staff, and family of the precautions needed. RN #2 stated visitors would need to wear a gown if they went in to visit and were at risk if there was no signage on the door. Continued interview revealed the Care Plan should have been revised to include interventions related to the C-Diff.</p> <p>The MDS Coordinator was unable to be interviewed related to being off on leave.</p> <p>Interview with the Director of Nursing (DON), on 06/19/15 at 1:30 PM, revealed for any MDRO and C-Diff, there should be signage on the door in</p>	F280	<p>The Nurse Manager will monitor for new diagnoses of C-Diff or MDRO. When identified, the Nurse Manager will audit the care plan to ensure that the care plan was revised to reflect the diagnosis and need for contact precautions as appropriate. Daily monitoring will begin on 7/14/15 and will continue on-going. The Infection Control nurse will complete weekly audits of 10% of the residents diagnoses with C-Diff or MDRO beginning 7/24/15 to ensure that the care plan has been updated to reflect the diagnosis and the need for contact precautions. The Infection Control Nurse will monitor weekly for 12 weeks and then monthly for the next 9 months.</p> <p>All staff will be re-educated regarding the policy for contact precautions, including the need for signs on the resident room doors, PPE usage and location. This education will be conducted by the staff development nurse, nurse manager, MDS nurse, or ADON by 7/31/15.</p> <p>All MDS nurses were educated on 6/18/15 by the DON of the need to update the plan of care to reflect the diagnoses of C-Diff and MDRO's to include the diagnoses and need for contact precautions.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning care plan interventions related to C-Diff and MDRO's will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p>	
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F280	Continued From page 16 order to alert family and visitors of the need to check with the nurse before entering. Further interview revealed gowns were available for use and kept at the nurses station and she did not think it was necessary to always wear a gown for incontinence care or changing bed linens for a resident with C-Diff; however, review of the facility "Contact Precautions" Policy, revealed a gown was needed to enter the room of a resident who had diarrhea caused by C-Diff if substantial contact with the resident or environmental surfaces was anticipated. Continued interview revealed the MDS Coordinators revised the Care Plans and Resident #26's Comprehensive Plan of Care should have been revised related to the resident's diagnosis of C-Diff and the need for contact precautions.	F280	Compliance with care plan updates will be reviewed and analyzed at each QA/PI meeting by the DON during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.  The "Contact Precautions" policy was reviewed and determined to be appropriate on 6/22/15 by the DON.	
F282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure the Care Plan was followed for two (2) of twenty-nine (29) sampled residents (#16 and #8). Staff failed to follow contact precaution procedures related to a diagnosis of Clostridium Difficile (C-Diff) for Resident #16, and failed to notify the Physician when the resident's symptoms of C-Diff recurred. In addition, the facility failed to ensure Resident	F282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS / PER CARE PLAN  Rosedale Green is committed to ensuring the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	8/3/2015

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F282	<p>Continued From page 17</p> <p>#6 received the nutritional supplement "Magic Cup" with each lunch and dinner meal.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Planning/Care Conferences", dated effective 06/01/08 and revised on 04/01/12, revealed it was the goal of the facility, through care planning/care conference activities, to achieve and maintain each resident's highest level of physical and mental functioning. Continued review revealed care plan interventions were put in place to direct resident care, based on the facility's assessments of the resident.</p> <p>Review of the medical record revealed Resident #16 was admitted by the facility on 05/21/15, and readmitted on 06/09/15 after a hospitalization, with diagnoses which included Debility, Diarrhea, C-Diff and Urinary Incontinence. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/28/15, revealed Resident #16 was assessed by the facility to be occasionally incontinent of bladder and frequently incontinent of bowel. Review of Bowel Movement (BM) records revealed Resident #16 had continent BMs of "loose to liquid" consistency on 06/12/15 and 06/15/15. Continued review revealed the resident had an episode of incontinent BM of loose consistency on 06/16/15.</p> <p>Review of the Care Plan for Resident #16, dated 05/21/15, revealed a problem of Gastrointestinal (GI) Concerns related to C-Diff and hemorrhoids. (C-Diff is a highly contagious bacterial organism that causes an infection of the intestinal tract.) Continued review revealed the Care Plan was updated on 05/22/15 to include an intervention to</p>	F282	<p>The policy and procedure "Care Planning / Care Conferences" was reviewed on 6/22/15 by the DON and determined to remain appropriate.</p>	

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F282	<p>Continued From page 18</p> <p>notify the Physician if the resident experienced loose stools. Additional interventions included directives to maintain contact precautions related to the resident's diagnosis of C-Diff.</p> <p>Further review of the medical record revealed no documented evidence the Physician was notified per the Care Plan when Resident #16 had continued and/or recurrent symptoms for C-Diff, as evidenced by BM records.</p> <p>Observation, on 06/16/15 at 10:45 AM, revealed Certified Nursing Assistant (CNA) #10 leaving Resident #16's room. Continued observation revealed no evidence CNA #10 used PPE while in the resident's room, nor was any PPE readily available for use. Furthermore, a sign on the resident's door did not clearly identify Resident #16 to require contact precautions. Interview with CNA #10 at the time of the observation revealed she was not aware if Resident #16 was supposed to have contact precautions.</p> <p>Observation, on 06/16/15 at 4:52 PM, revealed CNA #12 failed to follow contact precaution procedures related to C-Diff, including the use of PPE, when she cared for Resident #16 in his/her room. Interview with CNA #12 at the time of the observation revealed the facility's process was to store PPE items at the door of the resident's room for use in care. She stated she was not aware contact precautions were required for Resident #16.</p> <p>Subsequent interview with CNA #12, on 06/16/15 at 4:52 PM, revealed she had not been aware of the contact precautions, as care planned, for Resident #16 prior to 06/16/15, nor had she known of the resident's diagnosis of C-Diff. She</p>	F282	<p>Resident #16's physician was notified that the resident continued to have loose stools on 6/19/15 by the charge nurse.</p> <p>With regards to Resident #16, the sign on the door indicated the resident was in contact precautions (see citation in F157).</p> <p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #10 not only through report during the shift change huddle, but also via the Point of Care (POC) electronic medical record system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #10, reflected that this resident was under contact precautions.</p> <p>PPE was readily available to staff in the nurse's nook.</p> <p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #12 not only through report during the shift change huddle, but also via the Point of Care (POC) system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #10, reflected that this resident was under contact precautions.</p>	

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F282	<p>Continued From page 19</p> <p>stated PPE should have been available at the entrance to the resident's room and she should have worn a gown as well as gloves, as care planned, for toileting the resident.</p> <p>An interview with the Nurse Manager, on 06/16/15 at 4:58 PM, revealed Resident #16 was under contact precautions. She stated it was the responsibility of the nurse managers to place a "Contact Precautions" sign on the resident's door and to notify staff in the "huddle room" of the resident's condition and necessary precautions. She acknowledged Resident #16 was not clearly identified to require contact precautions.</p> <p>Interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse, on 06/16/15 at 5:13 PM, revealed Resident #16 was care planned when readmitted to the facility to have an active diagnosis of C-Diff. She stated the resident was placed on contact precautions and all staff were notified in the facility's "Huddle" meeting of the resident's care needs. She further stated Resident #16 no longer needed contact precautions because he/she was without active diarrhea. Continued interview revealed if the resident had active diarrhea, staff should wear a gown when assisting the resident to the toilet.</p> <p>Further interview with the ADON, on 06/17/15 at 5:41 PM, revealed she had not been informed that the resident's symptoms had returned. She stated it was the responsibility of the nurses to notify the Physician and continue with contact precautions. She further stated PPE items should have been placed outside the door of the resident. Continued interview revealed, based on the resident's BM report, the resident still may have C-Diff. and the CNAs failed to follow the</p>	F282	<p>PPE was readily available to staff in the nurse's nook.</p> <p>All nursing staff will be inserviced as of 7/31/15 by the ADON, staff educator, nurse manager, MDS / RAI nurse, or nursing supervisor reminding them that they are to refer to the POC system to determine specific care needs of each resident each shift.</p> <p>All facility staff will be inserviced as of 7/31/15, regarding the infection control protocol required when providing care for a resident that requires more than Standard Precautions. This includes a sign placed on the residents door that reads "Please See Nurse Before Entering". The nurse will then give them additional information regarding infection control procedures. If at any time they are unclear as to why the sign is in place, they are expected to see the nurse before entering. This training will be conducted by their department director, department supervisor, ADON, staff educator, nurse manager, or MDS / RAI nurse This inservice also included the proper use of PPE and where it is located.</p> <p>All nurses will be inserviced as of 7/31/15 by the ADON, staff educator, nurse manager, MDS / RAI nurse, or nursing supervisor that the physician must be notified when the resident has experienced a change in condition.</p>	

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F282	<p>Continued From page 20</p> <p>facility's process and Care Plan for contact precautions as it related to C-Diff and the care of Resident #16. She also stated the facility failed in its implementation of care plan interventions to notify the Physician when the symptoms of C-Diff returned for Resident #16. Further interview revealed a concern of the spread of the infection to other residents if proper precautions were not followed.</p> <p>Interview with the Director of Nursing (DON), on 06/17/15 at 6:13 PM, revealed the facility failed to follow the Care Plan as it related to C-Diff. notify the Physician when Resident #16 had a return of symptoms for C-Diff infection. She further stated the facility failed to</p> <p>2. Review of the medical record revealed Resident #6 was admitted by the facility on 06/21/11 with diagnoses which included Anemia, Debility, Alzheimer's Disease, Diabetes, Chronic Kidney Disease, Chronic Heart Failure, and Right Side Hemiplegia (Weakness of the entire right side of the body). Review of the Quarterly Minimum Data Set Assessment, dated 05/05/15, revealed the facility assessed the resident to be severely cognitively impaired. Resident #6's comprehensive Care Plan revealed the resident was at risk for significant weight loss and nutritional interventions included the directive to offer Magic Cup (a nutritional supplement) at lunch and supper.</p> <p>Observation of the evening meal service on 06/16/15 at 5:03 PM, and the noon meal service on 06/18/15 at 12:45 PM, revealed Resident #6 had no Magic Cup supplement served with the meals.</p>	F282	<p>All residents requiring contact precautions have the potential to be affected. On 6/18/15, an audit was completed by the Neighborhood Nurse Managers to ensure all residents with C-Diff and MDRO had signs placed on their doors stating "Please See Nurse Before Entering". On 6/18/15 and 6/19/15, the MDS nurses reviewed the care plans for all residents with C-Diff and / or MDRO if needed, the care plan was updated to reflect the need for contact precautions.</p> <p>With regards to Resident #6, the dietary supervisor was contacted by the nurse manager on 6/19/15 to ensure that the magic cup was available with each meal per the plan of care.</p> <p>All residents receiving a magic cup with meals have the potential to be affected. On 6/18/15, all residents with magic cups were identified by the Nurse Manager. Dietary was consulted to ensure that the magic cups are available at each meal for each resident per their plan of care.</p> <p>All nursing and dietary staff will be inserviced as of 7/31/15 by their department manager or supervisor, or nursing supervisor, staff development, nurse manager, MDS nurse of ADON that the magic cup is to be provided as part of the meal, not as a supplement based on the percentage of the meal consumed.</p>	

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F282	<p>Continued From page 21</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 06/19/15 at 5:00 PM, revealed the Care Plan was not followed when Resident #16 did not receive Magic Cup with his/her meals. She stated the supplement was always supposed to be given with lunch and dinner.</p> <p>Interview with the Dietician, on 06/19/15 at 10:30 AM, revealed the Magic Cup supplement was a nutritional intervention to ensure the resident got additional calories to help prevent weight loss. The Dietician reported staff were not following the Care Plan if the supplement was not offered with the designated meals.</p> <p>Interview with Registered Nurse (RN) #4/Unit Manager (UM), on 06/19/15 at 4:24 PM, revealed the care plan intervention was to offer Magic Cup at lunch and dinner. RN #4/UM stated staff was to offer the supplement and encourage the resident to eat it during meals because the resident needed the extra calories from the Magic Cup. She reported if the supplement was not given with the meal, staff was not following the care plan.</p> <p>Interview with the Director of Nursing (DON), on 06/19/15 at 5:13 PM, revealed the Magic Cup was a care plan intervention put in place to help prevent weight loss. She acknowledged staff did not follow the Care Plan when the supplement was not served with every lunch and dinner meal.</p>	F282	<p>Monitoring of care provided according to the care plan will be completed weekly by the nurse manager, MDS nurse or ADON by reviewing facility activity reports to identify pertinent changes. Audits of at least 10 orders per week per neighborhood will be completed each week by the nurse manager, MDS nurse or ADON. All audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p> <p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/3/15 and will continue weekly for 4 weeks. The audits will continue monthly for 6 months.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning care being provided according to the care plan will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The DON is responsible to ensure compliance with the provision of care according to the care plan. This topic will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	8/3/2015
F325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p>			

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F325	<p>Continued From page 22</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents maintained acceptable parameters of nutritional status, to the extent possible, for one (1) of twenty-nine (29) sampled residents (Resident #6), as evidenced by the facility's failure to ensure the Dietician's recommended nutritional supplement intervention was followed. In addition, the facility failed to inform the Physician and the Dietician of a significant weight loss, and failed to inform the Dietician of a change in the resident's therapeutic diet, per family preference, from Mechanical Soft to Regular Diet.</p> <p>Resident #6 had a history of weight loss and had an intervention to receive the supplemental "Magic Cup" at lunch and dinner. However, the resident was not always provided the Magic Cup during meals. The Dietician was not made aware of a change in Resident #6's mechanical soft therapeutic diet, ordered 05/02/15, to allow deviation for comfort foods related to palliative care and the family's request. In addition, the Dietician and the Physician were not notified Resident #6 had a significant weight loss when weighed on 06/07/15.</p>	F325	<p><b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b></p> <p>Rosedale Green is committed to maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem.</p>	8/3/2015

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F325	<p>Continued From page 23</p> <p>The findings include:</p> <ul style="list-style-type: none"> <li>Review of the facility's policy titled "Weight Changes", revised date 11/11/13, revealed changes in weight were to be monitored, addressed, and communicated to the Dietician and the Physician for evaluation and possible interventions. Continued review of the policy revealed the resident was to be assessed to determine the cause of the weight change. Further review revealed weights were to be obtained at least monthly, and each weight was to be compared to prior weights in order to identify progressive weight changes. Furthermore, according to the policy, the facility defined significant weight loss as a 5% change in one (1) month, a 7.5% change in three (3) months, or a 10% change in six (6) months.</li> <li>Review of the facility's policy titled "Change of Resident Condition, Family and Physician Notification", revised date 03/02/13, revealed it was expected the Physician would be notified, as soon as feasibly possible, regarding any significant change in the resident's physical status. Furthermore, notification of the Physician was to be documented in the medical record.</li> <li>Review of the medical record revealed Resident #6 was admitted by the facility on 06/21/11 with diagnoses which included Anemia, Debility, Alzheimer's Disease, Diabetes, Chronic Kidney Disease, Chronic Heart Failure, and Right Side Hemiplegia (Weakness of the entire right side of the body). The medical record noted the resident was on palliative care, as of 04/24/15, with no aggressive treatment per family wishes. Review of the Quarterly Minimum Data Set Assessment.</li> </ul>	F325	<p>The policy and procedure on Weight Changes was reviewed on 6/22/15 by the Director of Nursing and the Dietitian and was determined to remain appropriate.</p> <p>The policy and procedure on Change of Resident Condition was reviewed on 6/22/15 by the DON and was determined to remain appropriate.</p>	

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F325	<p>Continued From page 24</p> <p>dated 05/05/15, revealed the facility assessed the resident to be severely cognitively impaired. Resident #6's comprehensive care plan revealed the resident was at risk for significant weight loss and had nutritional care plan interventions to include the following: monthly weights; and offer Magic Cup at lunch and supper related to weight loss.</p> <p>1. Observation of the evening meal service, on 06/16/15 at 5:03 PM, revealed Resident #6 had a regular textured meal which included a sandwich, pea salad, pasta salad, and sherbet; however, no Magic Cup supplement was served.</p> <p>Additional observation of meal service, on 06/18/15 at 12:45 PM, revealed Resident 36 was being supervised/assisted by staff with the meal, which included bean and ham soup, carrots, cornbread, and cake, but no Magic Cup.</p> <p>Observation of the resident's meal ticket revealed Magic Cup was listed under the section which indicated the resident's likes.</p> <p>Interview with the Unit Coordinator Clerk, on 06/18/15 at 12:45 PM, revealed she routinely assisted Resident #6 with meals. She stated the resident did not have a Magic Cup supplement at this time, but she would offer the Magic Cup when the resident was not eating because it added extra calories.</p> <p>Interview with Certified Nursing Assistant (CNA) #13, on 06/18/15 at 1:09 PM, revealed when she assisted Resident #6, she offered the Magic Cup at the beginning of the meal; if the resident refused, she didn't always serve it unless Resident #6 did not eat much of the meal.</p>	F325	<p>With regards to Resident #6, dietary was contacted by the nurse manager on 6/19/15 to ensure that the magic cup was available with each meal per the plan of care.</p> <p>All residents receiving a magic cup with meals have the potential to be affected. On 6/18/15, all residents with magic cups were identified by the Nurse Manager. Dietary was consulted to ensure that the magic cups are available at each meal for each resident per their plan of care. Staff were also instructed how to obtain a magic cup if one is not provided with the meal tray.</p> <p>All nursing and dietary staff will be inserviced as of 7/31/15 by their department manager or supervisor, or nursing supervisor, staff development, nurse manager, MDS nurse or ADON that the magic cup is to be provided as part of the meal, not as a supplement based on the percentage of the meal consumed.</p> <p>All nursing staff will be inserviced as of 7/31/15 by the nursing supervisor, staff development, nurse manager, MDS nurse or ADON on the policy regarding weight changes.</p>	

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F325	<p>Continued From page 25</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 06/18/15 at 12:54 PM, revealed Magic Cup was supposed to be offered at lunch and dinner meals because it provided extra calories. The LPN stated Resident #6 had no Magic Cup supplement at this time because staff were probably waiting to offer it at the end of the meal since the Magic Cup was not as nutritious as the meal. LPN #3 reported the meal ticket listed Magic Cup under "likes", which indicated it was something the resident liked to have; however, she reported staff were aware the resident had experienced weight loss and staff typically offered the Magic Cup at the end of the meals.</p> <p>Interview with the Dietician, on 06/19/15 at 10:30 AM, revealed the Magic Cup supplement was a nutritional intervention to ensure the resident got additional calories, and was intended to ensure the resident received Magic Cup with meals. The Dietician revealed the supplement was not supposed to be offered based on the percentage of the meal consumed, but was provided for additional calories to help prevent weight loss.</p> <p>Interview with Registered Nurse (RN) #4/Unit Manager (UM), on 06/19/15 at 4:24 PM, revealed staff were supposed to offer/encourage the Magic Cup supplement during meals, not after meals, to provide extra calories. RN #4/UM revealed failing to provide the extra calories contained in the Magic Cup had the potential to impact the resident's nutrition negatively.</p> <p>Interview with the Director of Nursing (DON), on 06/19/15 at 5:13 PM, revealed staff were to provide the Magic Cup with lunch and dinner as an intervention to prevent weight loss.</p>	F325	<p>Monitoring of care provided to maintain nutritional status will be completed weekly by the nurse manager, MDS nurse or ADON by reviewing facility activity reports to identify pertinent changes. Audits of at least 10 nutrition related orders per week per neighborhood will be completed each week by the nurse manager, MDS nurse or ADON. All audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p> <p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/3/15 and will continue weekly for 4 weeks. The audits will monthly for 6 months.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning care being provided to maintain nutritional status will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The DON is responsible to ensure compliance with the provision of care according to the care plan. This topic will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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NAME OF PROVIDER OR SUPPLIER  ROSEDALE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
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F325	<p>Continued From page 26</p> <p>2. Review of weight reports for Resident #6 revealed on 06/07/15 the resident's weight was 163#, and was flagged by the system because the percent weight change in thirty (30) days was not in the acceptable range. Continued review revealed a 6.3% weight loss from 05/29/15 when resident's recorded weight was 174 pounds. According to the facility's policy, this was a significant change in weight. Further review of recorded weights revealed when the 06/07/15 weight was compared to the 03/01/15 weight of 185 pounds a three (3) month significant weight loss of 11.9%, and when compared to the 12/13/14 weight of 198 pounds there was a six (6) month significant weight loss of 17.7%. However, there was no documented evidence the facility notified the Physician or the Dietician of the weight loss.</p> <p>Further interview with the Dietician, on 06/19/15 at 10:30 AM, revealed if the 06/07/15 weight triggered loss nursing should have notified her. The Dietician stated Resident #6 was on palliative care and the weight loss was expected. She further stated she should have been notified of the weight loss by nursing in a timely manner. The Dietician reported when weight loss was reported she assessed the resident's nutritional intake, laboratory results, medications, weight history, appetite, and supplemental intake, and collaborated with nursing to determine appropriate interventions, even if the resident was on palliative care.</p> <p>Continued interview with the DON, on 06/19/15 at 5:13 PM, revealed Resident #6's weight loss was expected due to the resident's medical condition. Continued interview revealed if weight loss was</p>	F325	<p>All residents are weighed monthly, unless otherwise requested by the interdisciplinary team. The dietician reviews these weights entered into the medical record each month.</p> <p>The dietitian was notified of resident #6's new weight change on 6/18/15. The Dietitian recommended the following: "d/c routine monthly wts as loss continues despite supplementation/interventions and further wt loss may be unavoidable given dx/POC- notified nurse to f/u with MD/family. Staff to encourage snacks/fluids throughout the day and work with IDT to maximize comfort.". The physician was notified and order was obtained to d/c monthly weights due to expected decline, but weights continue to be obtained due to family wishes.</p> <p>Any resident with a change in condition, including weight loss, has the potential to be affected if this policy is not followed. Therefore, all staff who report changes in condition to the physician or dietitian will be inserviced by 7/31/15. These inservices will be given by the Nurse Managers, ADON, MDS/RAI nurse, staff development and Nursing Supervisors and include the expectation that staff monitor for and notify the physician and dietitian when an appropriate change in condition has been identified.</p>	

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F325	<p>Continued From page 27 identified, staff were supposed to re-weigh the resident for accuracy, and notify the Physician and the Dietician to allow them to determine any interventions.</p> <p>3. Observations of meal service, on 06/16/15 at 5:03 PM and on 06/18/15 at 12:45 PM, revealed Resident #6 was served regular textured meals and not pureed texture. Observation of the resident's meal ticket revealed Pureed Diet, but included under instructions "may deviate from pureed diet".</p> <p>Record review revealed an order, dated 05/02/15, to allow deviation from diet for comfort foods/fluids related to palliative care.</p> <p>Further interview with the Dietician, on 06/19/15 at 10:30 AM, she was not aware of the order allowing a regular diet until she read a progress note dated 06/18/15. The Dietician revealed interventions were limited with a Pureed Diet, but there was a breakdown in communication when she was not made aware the resident received a regular diet, which allowed more intervention options.</p> <p>Further interview with the DON, on 06/19/15 at 5:13 PM, revealed staff were supposed to notify the Dietician any time a Waiver was signed related to a resident's diet adjustment.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>	F325	<p>Monitoring of physician and dietitian notification of changes related to weight changes will be completed weekly by reviewing the facility weight reports to identify pertinent changes. Audits will be completed each week by the neighborhood nurse manager or ADON. All audits will be given to the ADON/QA Nurse so that a weekly audit can be completed and, if any, trends identified.</p> <p>The ADON/QA Nurse will compile these audits on a weekly basis beginning 8/3/15 and will continue weekly for 4 weeks. The audits will monthly for 6 months.</p> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning notification of changes related to weight changes will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The DON is responsible to ensure compliance with notification of changes. This topic will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	8/3/2015
F371 SS=F				

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F371	<p>1. Continued From page 28</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure food was stored under sanitary conditions as evidenced by observation of insects in the kitchen by the dishwasher area.</p> <p>The findings include:</p> <ul style="list-style-type: none"> <li>Review of the facility's policy titled: "Food Storage" last revised date 04/26/10, revealed food was kept safe and stored by methods designed to prevent contamination.</li> <li>Observation with the Dietary Manager (DM), on 06/17/15 at 2:54 PM, revealed two (2) insects were observed near the dishwasher area. The insects were trapped in a plastic cup, by the surveyor, and given to the Dietary Manager. In addition, another insect was observed in the area at approximately 3:00 PM.</li> <li>Interview, on 06/17/15 at 3:00 PM, with Dietary Aide #1 revealed she only worked in the dish room area occasionally and had not seen any insects and cleaned the floor twice a day.</li> <li>Interview with the DM, on 06/17/15 at 3:11 PM and at 3:20 PM, revealed there was not supposed to be any insects in the kitchen and as soon as</li> </ul>	F371	<p>483.35(I) FOODPROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>Rosedale Green is committed to procuring food from sources approved or considered satisfactory by the Federal, State, or Local authorities; and to store, prepare, distribute, and serve food under sanitary conditions.</p> <p>The policy and procedure on Food Storage was reviewed by the Director of Dietary Services on 6/17/2015 and was determined to be appropriate.</p> <p>On 6/17/2015 when the insects were noted near the dishwasher area the Environmental Service Director was requested to contact the facility's Pest Control Vendor.</p> <p>As noted, the Pest Control Technician was in the facility on 6/18/2015 to provide additional treatment to the dishwasher area. The technician reported to the OIG survey that he was in the facility twice a month and he always felt the kitchen looked very clean and that he felt the insects more than likely arrived at the facility through the delivery (large cardboard boxes) process.</p>	8/3/2015

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F371	<p>Continued From page 29</p> <p>someone saw a bug they were supposed to call pest control. The DM reported there was potential the bugs could get into food, it was an infection control issue and was going to report the insect sighting to the housekeeping supervisor to call pest control.</p> <p>Further observation and interview with the DM and Dietary Director, on 06/17/15 at 3:35 PM, revealed there were a few bread particles on the floor by the cooking area. The DM revealed the area was supposed to be cleaned by the day cook prior to the end of the shift, but didn't appear like it was cleaned and that could attract bugs. The Dietary Director revealed insects were not supposed to be in the kitchen area and they mopped floors at night and day shift was supposed to sweep the floors before they left at 2:30 PM.</p> <p>Interview, on 06/18/15 at 11:05 AM with the Dietary Aide #2 revealed they swept the floor around the baking and cooking areas routinely, but had not swept the area behind the machines yesterday (06/17/15) because it was hard to sweep around the machines. Further interview with the Dietary Aide revealed she had never seen any bugs, but sweeping helped keep food sources away from bugs.</p> <p>Interview, on 06/18/15 at 12:30 PM with the Pest Control Technician revealed the insects were roaches which probably came in with food products brought into the facility. He stated food products and grease can attract bugs and it was important to keep the area clean. He reported they came twice a month and the kitchen looked clean.</p>	F371	<p>All dining staff will be in serviced by the Director of Dietary or Dietary Supervisors on the procedure to follow if a bug/pest is sighted in the dish washing, food preparation, food storage or food serving area. This in-service will be completed prior to 7/31/2015.</p> <p>The master cleaning schedule for the kitchen is current being revised by the Director of Dietary and will be completed by 7/24/15. All dietary staff will be educated on the updated Master Cleaning Schedule prior to 7/31/15 by the Director of Dietary or Dietary Supervisor to ensure that floors are routinely receiving a deep cleaning and to increase monitoring for pest sightings.</p> <p>Dietary Aide #2 was inserviced on 6/18/2015 by the Dietary Supervisor on the proper procedure for sweeping the floor, including the area behind the machines.</p> <p>Monitoring of the kitchen for pest will be completed daily by the dietary staff. The Dietary Supervisor will complete audits of all kitchen areas including dish washing, food preparation, food storage or food serving area on a weekly basis. The Dietary Supervisor will provide the Dietary Director a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning the physical environment, specifically the shower rooms and resident bathrooms will be reviewed at the regular QA/PI meetings, and as necessary, at any subsequent special meetings called during the review period to ensure ongoing compliance.</p>	

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F371	1 Continued From page 30 Interview, on 06/19/15 at 6:09 PM, with the Administrator revealed she had been made aware they had some bugs down in the kitchen by the dishwasher area, but not the food preparation area, during the survey. The Administrator revealed they kept food covered and wrapped to prevent contamination but there was the potential of an infection control concern with the bugs. Further interview revealed bugs were one reason it was important to keep the kitchen clean and follow the cleaning protocol.	F371	The Director of Dining Services is responsible for ensuring compliance with a safe, clean, comfortable homelike environment.	
F441 SS=F	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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  Rosedale Green is committed to establishing and maintaining 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.	8/3/2015

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F441	<p>1: Continued From page 31 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review, and review of facility's policies, it was determined the facility failed to 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 for nine (9) of twenty-nine (29) sampled residents (Residents #1, #3, #6, #7, #9, #10, #16, #26, and #27) and fifteen (15) unsampled residents (Unsampled Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, and P).</p> <p>The facility failed to have an effective system in place to monitor the disinfection of the whirlpool (w/p) tubs. Interviews with staff on the First and Second floors of the facility revealed they were unaware of how to properly disinfect the five (5) whirlpool tubs in the facility and were not using the disinfectant per manufacturers recommendations. There was no evidence of staff education on hire or ongoing related to</p>	F441	<p>Rosedale Green consistently monitors and reviews infections for patterns and trends on a monthly basis and in day to day practice and has noted no issues with cross contamination. An audit was completed by the Infection Control nurse on 6/19/15 of residents #3, #7, #9, #10, #27, and A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, AND P and no issues were noted with cross contamination.</p> <p>Of the 5 whirlpool tubs in the facility, one was out of service at the time of the survey and another was taken out of service during the survey due to a crack in the compartment area that stores the shampoos and disinfectant.</p> <p>Staff education is provided by the staff development coordinator upon hire to nursing assistants, documentation of which is included on a Skills Checklist completed during training. This information was shared with surveyors during their visit.</p>	

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F441	<p>Continued From page 32</p> <p>disinfecting of the tubs. In addition, there was no system in place to ensure the chemical in the tubs was at the right level and no person was responsible for checking the amount of cleaning chemical in the tubs. Interviews and record reviews revealed the following residents were using the whirlpool tubs: Unsampled Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, O and P and Residents #3, #7, #9, #10, and #27.</p> <p>Also, observation of Resident #10 revealed Foley catheter tubing was touching the floor on two (2) separate occasions.</p> <p>Observation of indwelling urinary catheter irrigation for Resident #10 revealed the Licensed Practical Nurse (LPN) irrigated the catheter with Normal Saline; however, then attached the used urinary drainage tubing to the catheter instead of allowing the fluid to drain back into the basin as per facility policy. In addition, the nurse raised the urinary drainage bag above body level causing the urine to backflow after the catheter irrigation. After the irrigation of the indwelling urinary catheter, the nurse then without removing the soiled gloves and washing hands, adjusted the side rail and lowered the bed using the bed control with the same soiled gloves.</p> <p>In addition, observation of indwelling urinary catheter care for Resident #10, revealed the Certified Nursing Aide (CNA) failed to pull the resident's foreskin back down after catheter care, and failed to wash her hands after the procedure, prior to exiting the room.</p> <p>Observation during initial tour revealed four (4) rooms with Oxygen tubing or Hand Held Nebulizer's (HHN's) tubing not bagged and not in</p>	F441	<p>In addition, instructions for disinfecting the whirlpool tubs was displayed on the wall at the head end of each whirlpool tub.</p> <p>The policy and procedure for disinfecting the whirlpool tubs was reviewed and updated by the DON on 6/18/15. Updates included specific instructions related to each type of tub as well as clarification of the use of sani-wipes for cleaning the tubs that have jets.</p> <p>With regards to Resident #10, an audit was completed by the Infection Control Nurse on 6/19/15 and no negative outcomes were noted related to the catheter bag having been noted on the floor, from the nurse having re-attached the catheter tubing allowing the normal saline to flow into the catheter bag, or from the catheter bag having been lifted above the level of the bladder (according to the nurse, the tubing was not attached to the bag at the time), or from the foreskin having not been pulled back into place after catheter care..</p>	

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F441	<p>Continued From page 33</p> <p>use during the tour.</p> <p>Resident #16 was to be in contact isolation for Clostridium Difficile (C-Diff) (a very contagious bacterial organism that causes an infection of the intestinal tract); however, there was no signage on the door or Personal Protective Equipment (PPE) readily accessible. In addition, the CNA caring for the resident was unaware the resident was to have precautions related to C-Diff. Also, although the resident had stopped having loose stools and was being treated with medication, the Physician was not notified when the resident again started having loose stools.</p> <p>Resident #26 was being treated for C-Diff; however, there was no signage on the door to alert staff, family, and visitors and there was no PPE readily accessible for use.</p> <p>Observation of a dressing change for Resident #6 revealed the nurse placed the clean dressing on the table prior to the dressing change instead of using a barrier.</p> <p>Observation revealed poor handwashing and glove use during a skin assessment for Resident #1.</p> <p>The findings include:</p> <p>Review of facility's "Nursing Infection Control Procedures", undated, revealed proper infection control procedures must be maintained at all times to ensure the well being and safety of the Residents. Our residents are highly susceptible to illnesses due to chronic health conditions, weakened immune systems, poor nutritional/fluid intake and inadequate sleep, etc. If we are not</p>	F441	<p>The policy and procedure on Nursing Infection Control Procedures was reviewed on 6/22/15 by the Infection Control Nurse and the DON and was determined to remain appropriate.</p>	

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F441	<p>Continued From page 34</p> <p>careful in the practices we use, we can increase the risk of spreading infections to the residents and throughout the facility.</p> <p>1. Review of Facility's "Cleaning and Disinfecting of Whirlpool/Tub policy and procedure", undated, revealed all equipment must be cleaned and sanitized after each resident's use to insure a safe and sanitary environment for all residents. Review of the procedure revealed staff should empty the tub and remove any visible debris. Whirlpool tubs have sanitizer set by manufacturer to mix with the correct amount of water as it is sprayed from the hose connection. Sanitizer solution is two (2) oz per gallon of water: Spray all hard surfaces with sanitizer spray using a clean cloth to remove any debris noted, then spray that area again (after removal of debris) with sanitizer. After all areas are sanitized let tub air dry. The tub is now ready for use. Review of the section for Alternate Sanitizer revealed to empty the tub of water and remove any visible debris. Clean tub thoroughly with 1:10 bleach solution. Wipe all hard surfaces and let set two (2)-three (3) minutes. Rinse thoroughly. The tub is now ready for use. Continued review for Alternate Sanitizer revealed to empty tub of water and remove any visible debris. Clean tub thoroughly. Wipe all hard surfaces with Sani-Cloth Germicidal Disposable Wipe. Let Germicidal solution set for 2 minutes on all hard surfaces. Rinse thoroughly. The tub is now ready for use.</p> <p>Review of the Arjo "Symphony" Manufactures Recommendations for Operating and Daily Maintenance, undated, revealed to disinfect the tub, the procedure should be followed at the beginning of the day, after each bath and at the</p>	F441	<p>The policy and procedure on Cleaning and Disinfecting of Whirlpool/Tub was reviewed by the Staff Development nurse and the DON on 6/18/15 and was revised to include manufacturer's specific recommendations for each type of whirlpool tub in use (Arjo Symphony and Rhapsody Primo). The policy was updated to include information related to the tubs automatic mixing of chemicals, what to do if you have to manually mix the chemicals, and that cleaning is required at the beginning of the shift before use, between uses, and at the end of the shift when all whirlpool baths have been completed for the day.</p>	

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F441	<p>Continued From page 35</p> <p>end of the day. (1) Open the panel cover and check that the Arjo Disinfection/Cleaner has an ample supply and the hose was connected. (2) Drain bath water and rinse sides and bottom of empty tub with clean luke warm water from the white resident shower. (3) Detach the disinfectant spray handle from the hook. (4) Close the drain. (5) Press the disinfectant spray button and spray disinfectant around the bath surface. (The disinfectant pump will run for maximum of five (5) minutes, but could be stopped when desired by pressing the disinfectant spray button). (6) Allow two (2) minutes for the disinfectant to kill microorganisms. (For complete disinfection, read the instructions on the container). Use a soft bristled brush or disposable clothes/paper towels to scrub the bath surfaces. If a brush was used, it should be soaked in disinfectant, rinsed in cold water and air dried after use. (7) Open the drain and rise tub surfaces with clean water from the white handled shower. (8) Wipe the tub with a clean cloth to remove excess water.</p> <p>Review of the Arjo "Rhapsody/Primo" Manufactures Recommendations revealed the Operating and Product Care Instructions, dated March 2003, stated the Arjo Cen-Kleen IV, a chemical, should only be used for optimal performance for this whirlpool/Stillbath and Hydrosound. Continued review of the manufactures recommendations revealed the procedure for disinfecting the tub should be performed before the first bath of the day and then after every resident. Continued review of the Manufactures Recommendations stated staff should make sure that there was an appropriate mixture of disinfectant liquid to the water by means of checking the flow meter or state of the water (for example the smell, foam). Further</p>	F441		

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F441	<p>Continued From page 36</p> <p>review of the Recommendations stated "staff" would (1) Raise the bath tub to convenient working height, by pressing arrow up button on the control panel. (2) Scrub and rinse tub and accessories, if necessary, to remove visible tissue residue or fluids before disinfection. (3) Close the drainage plug. (4) Remove inlet screen and clean it separately. (5) Remove the turnable hydromassage nozzle (Just pull it out). (6) Insert the treatment hose in the hydromassage outlet. (7) Press the automatic disinfection button. Automatic disinfection starts. The hydromassage equipment will be rinsed with Cen-Kleen IV for about ten (10) seconds. (8) Direct the disinfectant spray handle against the bottom of the bath tub. (9) Spray all the bath tub, the foot rest, the pillow and lift with mattresses, if any, with the disinfectant sprayer. (10) Spray into the surface overflow outlet and into the holes where the inlet screen and hydromassage nozzle were placed. (When the treatment hose was used, spray the outside too.) (11) Press the disinfectant button, and place the disinfectant spray handle under the lid. (12) Scrub the tub using the disinfectant at the bottom of the bath tub. (13) Let the Cen-Kleen IV take effect according to the recommendation label on the bottle. Recommended contact time was ten (10) minutes for Arjo Cen-Kleen IV. The system would be blocked for using as long as the LED on the disinfection button was on. (14) Open the drainage plug. (15) The hydromassage equipment was automatically rinsed with water when the preset disinfections/cleaning time has elapsed since the automatic disinfection button was pressed the first time. (16) When disinfection was finished: (Remove the treatment hose from the quick coupling by pushing the hose while pulling the hose bracket.) (17) Press the</p>	F441		
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F441	<p>Continued From page 37</p> <p>button for resident shower on the control panel, and rinse bath tub and accessories carefully with the resident shower. (18) Examine tub and accessories to ensure removal of disinfectant. Repeat rinse as needed. (19) Press the button for resident shower on the control panel. (20) insert the cleaned inlet screen, and make sure that the area without holes was directed downward. (21) Examine tub and accessories for visible damage. (22) Let the pillow dry with the suction cups upward at the bottom of the bath tub. (23) After the last cleaning/disinfection for the day, dry the bath tub and accessories.</p> <p>Review of the "Cen-Kleen IV" Cleaner and Disinfectant instructions for use, undated, revealed the Cen-Kleen IV was a concentrated product and should be diluted for final use. Staff was to apply two (2) ounces (oz.) of Cen-Kleen IV per one gallon of water with a contact time of ten (10) minutes.</p> <p>Review of the "Classic" Whirlpool Disinfectant Cleaner, undated, revealed the Classic was to be diluted with two (2) ounces of cleaner per gallon of water with a contact time for disinfection of ten (10) minutes and a Sanitizing time of thirty (30) seconds.</p> <p>Review of the "Super Sani-Cloth" Germicidal Disposable Wipe Instructions, undated, revealed it was a Premoistened nonwovens durable wipe containing a quaternary/alcohol based solution. It was recommended for use of non-porous surfaces and equipment made of stainless steel, plastic, Formica and glass. Some organisms were removed from the surface by thoroughly wiping the surface with the wipe; however, most remaining organisms were killed within two (2)</p>	F441		

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	<p>Continued From page 38</p> <p>minutes by exposure to the liquid in the wipe.</p> <p>Observation, interviews with the residents and staff, and review of the facility's "Whirlpool Schedule", revealed Unsamped Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, and P and Residents #3, #7, #9, #10, and #27 utilized the Whirlpools. Additionally, Resident #10 was being treated for Extended-spectrum Beta-lactamase (ESBL).</p> <p>Observation and interview with CNA #3, on 06/17/15 at 9:55 AM, on Willow Glen within the Women's bathroom, which had the Arjo "Symphony" Whirlpool model revealed CNA #3 was demonstrating to CNA #12 and several nursing assistants on how to "disinfect" the Whirlpool. CNA #3 was observed to turn the water on from the back of the whirlpool, not from the tub. She reported she had turned the water on this way for over three (3) years. She continued to instruct CNA #12 and the nursing assistants on cleaning the whirlpool by stating, "there was no chemical in the whirlpool", after checking to see if there was any chemical in it, she then turned on the water from the whirlpool and pressed the disinfectant knob, she reported there must have been chemical in the whirlpool since "water" was coming out of it. She reported the disinfectant would not work if there was no disinfectant in it. CNA #3 reported it was the responsibility of the Nurse Manager to change the disinfectant when it was low and/or out.</p> <p>Interview and observation with CNA #12, on 06/17/15 at 10:30 AM, in Willow Glen's Men's Bathroom, which had the Arjo "Rhapsody/Primo" Whirlpool Model, revealed she used the whirlpool last week, but did not recall it "not" working, when</p>		<p>With regards to residents #3, #7, #9, #10, #27, and A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, AND P, an audit was completed by the ADON on 6/19/15 and no issues were noted with cross contamination of ESBL.</p> <p>Maintenance was notified by the nurse manager on 6/17/15 to assess the situation with the whirlpool tub water being turned on from the back instead of the tub area.</p> <p>CNA #12 and #3 were inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>In-servicing for all nursing staff and housekeeping staff on the policy and procedure for cleaning and disinfecting the tubs was started on 6/18/15 and will be completed by 7/31/15 by the nurse manager, nurse supervisor, MDS nurse, staff development nurse or ADON. This training will include overall review of the policy, including but not limited to the proper process to clean the tubs, when to clean the tubs, how to verify that disinfectant is present and who is responsible to make sure the disinfectant is supplied to each tub and who to notify if it is noted that the disinfectant supply is low or out. Staff education also included that water will come out even when the disinfectant is out. All nurses, nursing assistants and housekeepers are expected to know how to clean and disinfect the whirlpool tubs.</p>	

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F441	<p>Continued From page 39</p> <p>attempting to cut the disinfectant on. She reported she normally assist the CNA's with whirlpools and thus did not have to clean the whirlpool. She reported she would clean the whirlpool by sanitizing the tub and rinsing well, additionally, she stated she would spray the disinfectant in the tub, but would immediately rinse it out with water. She reported there was no "waiting" period for allowing the disinfectant to sit on the surface of the tub.</p> <p>Interview with CNA #4, on 06/17/15 at 11:03 AM, on Willow Glen Men's Bathroom, revealed CNA #4 was unsure how the Whirlpool Jets were cleaned. She reported Maintenance/Housekeeping was responsible for ensuring the whirlpool had disinfectant in it. She reported that after spraying the disinfectant, staff should wait two (2) minutes before spraying the tub down with water. CNA #4 reported it was important to ensure the whirlpool was cleaned correctly due to infection control.</p> <p>Interview with CNA #5, on 06/17/15 at 11:15 AM, and observation/interview at 2:30 PM, the same day, within Willow Glen Men's Bathroom, revealed it was Maintenance responsibility for checking and replacing the disinfectant to the whirlpool. Continued interview with CNA #5 revealed she did not know how to clean the jets, but would find out from management. Further interview with CNA #5 revealed she would aim the disinfectant at the jet and let it sit for a few minutes before wiping it down. CNA #5 reported it was important to keep the whirlpools clean due to possible contamination. Additional interview/observation at 2:30 PM with CNA #5 revealed, CNA #5 was observed demonstrating an in-service to two (2) other CNA's (CNA #6 and</p>	F441	<p>All staff were inserviced beginning 6/17/15 to be completed by 7/31/15 by staff development, nurse manager, MDS nurse, charge nurse, department director or department supervisor on the procedure for filling out maintenance work orders for broken equipment.</p> <p>CNA #4 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>CNA #5 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	

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F441	<p>Continued From page 40</p> <p>CNA #13 on how to "disinfect" the whirlpool. CNA #13 reported she had been at the facility for four (4) months and reported this was the first time she had been trained on cleaning the whirlpool. Continued observation revealed that CNA #6 was unable to provide a demonstration on the proper technique to clean the whirlpool according to the manufacturer's recommendations. CNA #5 was observed to intervene, showing CNA #6 how to clean the jets. CNA #5 instructed CNA #6 on how to turn on the water from the whirlpool, then showing him how to turn the disinfectant on to disinfect the tub. Further interview with CNA #5 revealed, the Assistant Director of Nursing (ADON) refilled the whirlpool with disinfectant, due to the whirlpool not having disinfectant, approximately two (2) hours prior to the inservice/demonstration.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/17/15 at 4:38 PM, on Willow Glen, revealed she was aware of residents who received a whirlpool bath, but had never used the whirlpool to assist the residents with whirlpool baths. She reported she had not received any inservices on the whirlpool and cleaning/disinfecting the tubs. Continued interview revealed she thought Housekeeping was in charge of refilling the disinfectant. Further interview revealed it was important to disinfect the whirlpool due to infection control, to prevent the spread of diseases.</p> <p>Interview with Registered Nurse (RN) #1/Unit Manager, on 06/17/15 at 5:00 PM, located on Willow Glen, revealed the Staff Development Coordinator provided inservice on cleaning the whirlpools. She reported she was informed of the whirlpool policy on 06/17/15 and was informed</p>	F441	<p>With regards to CNA #13, her skills competency checklist was reviewed by the staff development nurse on 6/18/15 and it was noted that she had been checked off during training on how to clean and disinfect the whirlpool tubs.</p> <p>CNA #1, #5, and #6 were inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>LPN #2 inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>RN #1 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	

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F441	<p>Continued From page 41</p> <p>that staff should check the whirlpool to ensure disinfectant was present in the whirlpool before using it. She stated that if there was no solution present, staff would need to notify their supervisor or Unit Manager. She reported the Unit Manager or Clinical Coordinator should mix the mixture for the CNA's. Continued interview with RN #1 revealed it would be her expectation that staff would use the solution provided to them to put disinfectant in the whirlpool. She reported her unit used the "Classic Cleaner". If the unit was out of the "Classic", she reported she would expect her staff to use the Sani-Cloth, and thirdly (3rd), she would expect them to use a bleach solution. She reported she was not familiar with the Manufactures Recommendation for use, but would expect the policy would reflect the Manufactures Recommendations. Continued interview with RN #1 revealed it was important to clean the whirlpool "correctly" because of infection control purposes.</p> <p>Interview with CNA #7 on 06/17/15 at 2:40 PM, within the Autumn Wood Women's Bathroom, revealed she was unsure how long the disinfectant tank was broken on her unit. She reported she would use Sani-Wipes to wipe the whirlpool and allow the product to sit on the tub for two (2) minutes then would rinse out with water. She reported she used the Sani-Wipes to clean the outside of the jets. Continued interview with CNA #7 revealed residents who normally used the whirlpool were those who required a full body lift, or those who could not easily stand in the shower. She further stated there were; however, some that preferred the whirlpool.</p> <p>Interview with CNA #8 on 06/17/15 at 3:04 PM, on Autumn Wood, within the women's bathroom,</p>	F441	<p>Upon notification to the DON that the disinfectant tank on Autumn Woods Women's Bathroom whirlpool tub had a crack, the unit was taken out of service on 6/18/15.</p> <p>CNA #7 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>CNA #8 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	
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F441	<p>Continued From page 42</p> <p>revealed that there should not have been residue near the drain that was identified while inspecting the whirlpool with CNA #8. He reported the process for cleaning the whirlpool was to use a washcloth, Sani-Wipes and/or a bleach solution from housekeeping, and rinse with hot water. He reported it was important to ensure the whirlpool was cleaned correctly because, "it could lead to sickness", by not properly cleaning the whirlpool.</p> <p>Interview with CNA #9, on 06/17/15 at 3:27 PM, within Autumn Wood Women's bathroom, revealed the whirlpool was last used by her on 06/16/15. She reported she did not know the disinfectant solution was empty and was not familiar with how to clean the jets. She reported it was very important to disinfect and clean the whirlpool correctly or the residents could get an infection. She reported she would clean the whirlpool only if she thought the whirlpool was dirty by using Sani-Cloth wipes and a washcloth to clean the tub. She later reported she should clean the tub before and after each use.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/17/15 at 4:12 PM, located on Autumn Wood, revealed he inserviced a select few on cleaning the whirlpool with Sani-Wipes approximately six months ago. He reported the whirlpool had not been working for approximately six months due to a leakage in the disinfectant bottle. He reported Maintenance was notified and Maintenance notified a private contractor. Continued interview revealed Housekeeping was in charge of changing and ordering the disinfectant, adding it was important to clean the whirlpool correctly because of infection control reasons.</p>	F441	<p>CNA #9 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>LPN#1 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	

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F441	<p>Continued From page 43</p> <p>Interview with Registered Nurse (RN) #3/ Unit Manager, located on Autumn Wood, on 06/17/15 at 3:45 PM, revealed that staff received training upon hire for whirlpool use and cleaning. She reported she was unaware of how the jets were cleaned or what disinfectant was used to disinfect the whirlpool. Continued interview with RN/Unit Manager #3 revealed that staff should have notified her if there was no disinfectant. Additionally, she reported staff had not informed her that the whirlpool needed a disinfect for the past fourteen (14) months she had been the Unit Manager. She further stated the nurses, nurse managers, and housekeeping should be checking to ensure the whirlpool had disinfectant. She reported she would close the Whirlpool until she was better informed on the proper cleaning of the whirlpool.</p> <p>Interview with Nurse Manager #4, located on Magnolia Springs, on 06/18/15 at 12:00 PM, revealed "out of order" sign was placed on the whirlpool today and will stay on it until staff can verify proper cleaning and use of whirlpool. She was unsure how the whirlpool was cleaned. She stated CNA's and Housekeeping check disinfectant then check with him/her when it runs out and he/she would contact Maintenance and Central Supply. Continued interview revealed she was unsure who mixed the disinfectant and replaced it in the tub. She revealed that infection control could be an issue, adding it was "Nasty". She reported her expectations would be for staff to look at disinfectant and if unsure of procedure then find out.</p> <p>Interview with RN #2, located on Magnolia Springs, on 06/18/15 at 12:22 PM, revealed that she had not used the whirlpool. She reported she</p>	F441	<p>RN#3 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>Upon receiving notification that there were issues arising during the survey related to the whirlpool tubs, staff were instructed to refrain from using the tubs until administration was made aware of the exact nature of the surveyors concerns so that the issues could be assessed and addressed appropriately.</p> <p>RN #4 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>RN#2 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	
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F441	<p>Continued From page 44</p> <p>was unsure of how to use it correctly. Further interview from RN #2 revealed the Whirlpool should be cleaned before and after use. RN #2 reported this was important due to infection control. Continued interview with RN #2 revealed she was unsure of who would be responsible for refilling the disinfectant.</p> <p>Interview with CNA #14, on 06/18/15 at 11:30 AM, located on Millers Crossing, revealed the unit had an Arjo "Rhapsody/Primo" Whirlpool Model. She reported the whirlpool should be cleaned before and after each use. She stated she did not know how to replace the disinfectant, but would notify maintenance or Central Supply. While demonstrating the cleaning of the whirlpool, debris was found in the cap of the whirlpool tub, she reported "that should not have been there". After spraying the disinfectant, CNA #14 did not allow the chemical to "set" adding she would immediately rinse the tub out with water. She stated Millers Hall used the Cen-Kleen IV.</p> <p>Interview with LPN/Unit Manager/MDS #3, on 06/18/15 at 11:50 AM, located on Millers Crossing, revealed everyone was in-serviced regarding the whirlpool on 06/17/15. She reported the current policy did not reflect how long the chemical should set on the surface of the whirlpool tub and reported there was some conflict regarding the chemical's use for Millers Hall. She reported the ADON wrote the policy, thus she would be the one to answer the discrepancy in the Manufactures Recommendation and the Facility's Policy. Continued interview with the "acting" Unit Manager revealed it would be her expectation that the debris in the whirlpool should not have been in the whirlpool and that it was cleaned</p>	F441	<p>CNA #14 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p> <p>LPN #3 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	

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F441	<p>Continued From page 45 correctly due to infection control concerns.</p> <p>Interview with Housemaker #3, on 06/17/15 at 11:40 AM, revealed she was not responsible for changing the disinfectant in the whirlpool. She reported that was the responsibility of the CNAs.</p> <p>Interview with the Homemaker Manager, on 06/17/15 at approximately 12:30 PM, revealed her staff was not responsible for ordering or cleaning the whirlpool, adding she did not know which chemical staff used to clean out the Whirlpool. She reported the responsibility was nursing.</p> <p>Interview with the Director of Maintenance, on 06/17/15 at 10:05 AM, revealed nursing staff maintained the whirlpools. He reported his job was to repair any maintenance concerns, not to clean or order disinfectant for the units.</p> <p>Interview with ARJO service technician on 6/19/15 at 1:15 PM, revealed he recommended the facility used ARJO's cleaning products due to no animal fats used. He stated the facility has since ordered two and a half cases of Cen-Kleen and it should arrive the following morning. Continued interview with the Service Technician revealed he serviced the whirlpools once a year to provide maintenance and, as needed, for problems with the whirlpool throughout the year. The Service Technician reported the whirlpool jets were disinfected throughout by using the yellow sprayer. He stated the chemical used for the whirlpool would clean the jets automatically. Additionally, he stated "when spraying the whirlpool with bleach spray or Sani-Wipes, it would not clean the jets", therefore, he reported the jets were not being disinfected by the bleach</p>	F441	<p>Homemaker #3 was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs and the responsibility of ensuring that disinfectant was available and in use.</p> <p>The Homemaker Manager was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs as well as the responsibility of the staff.</p>	
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F441	<p>Continued From page 46</p> <p>spray or sani-wipes. Continued interview with the Service Technician revealed that the disinfectant "sprayer" would continue to work without solution in it; however, staff should check to see if any chemicals were in the whirlpool by checking the "smell", "soapy foam", and/or looking to see if any chemical/solution was in the whirlpool.</p> <p>Interview with Staff Development Coordinator, on 06/19/15 at 12:45 PM, revealed that training related to cleaning the whirlpool was discussed in class to new employees. She reported she reviewed the manufacturer recommendations with the staff. Continued interview with the Staff Development Coordinator revealed she instructed the staff on, how to check disinfectant level, how to fill with water, apply disinfectant, scrub or wipe down, allow to sit two (2) to ten (10) minutes, depending on what type of cleaner, how to hook up sprayer to jet, and how to clean the filter. The Staff Development Coordinator reported a returned demonstration was not a part of her training, she only provided the information to staff verbally. Further interview with the Staff Development Coordinator revealed, the preceptor's (seasoned CNA's) on the unit would continually provide in-service/demonstrations on cleaning the whirlpools to new employees. She reported the facility ensures the preceptors know how to clean the tubs based on their evaluations, before they show other CNA's how to clean it. Additionally, she reported there was no quality assurance monitoring done to ensure that the process was being done correctly. The Staff Development Coordinator reported it was important the whirlpool was cleaned correctly to prevent cross contamination. She reported the process for ensuring the whirlpools had disinfectant would be to notify their supervisor</p>	F441		

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F441	<p>1. Continued From page 47</p> <p>who would obtain the disinfectant from Central Supply. She reported the CNA should check to see if the whirlpool had disinfectant in it prior to cleaning the whirlpool.</p> <p>Interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse, on 06/19/15 at 11:36 AM, revealed staff was trained how to clean the whirlpool upon hire. She reported staff was to follow the Manufactures Recommendations when it came to disinfecting the whirlpools. The ADON reported she would look at the current policy to see where the discrepancy with the Manufacture's Recommendations were. She reported she could not make any changes to the policy on her own. Continued interview with the ADON revealed staff should not have used the whirlpool if there was no disinfectant in the whirlpool tub to clean it. She reported it was important to clean the tub effectively to prevent the transferring of infections.</p> <p>Interview with the DON, on 06/19/15 at 1:35 PM, revealed she was not aware of the concerns related to the whirlpool and was not familiar with the policy. She reported staff was in serviced on how to disinfect the whirlpools, adding "if we audited this, it was not done correctly". She reported it was important to ensure the whirlpool was cleaned correctly due to infection control. She further stated the Infection Control should do yearly competency related to disinfecting the whirlpools.</p> <p>Interview with the Administrator, on 06/19/15 at 5:45 PM, revealed she did not know when the facility began using the "Classic" disinfectant as opposed to the recommended disinfectant by the Arjo Company, Cen-Kleen IV. She reported she</p>	F441	<p>The ADON was inserviced on 6/18/15 by the staff development nurse on the proper procedure for cleaning and disinfecting the whirlpool tubs.</p>	
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F441	<p>1. Continued From page 48</p> <p>has since ordered the Cen-Kleen IV and that would be used for all of the whirlpools. Continued interview with the Administrator revealed that the cleaning of the Whirlpool should be completed by the Manufactures Recommendation. She reported it was important to clean the Whirlpool correctly because of infection control.</p> <p>2. Review of the facility's policy "Review of Nursing Infection Control Procedures", undated, revealed the dignity bag (bag containing the urinary drainage bag) and the Foley catheter tubing should not be allowed to touch the floor.</p> <p>Review of Resident #10's medical record revealed the facility admitted the resident on 03/24/09 with a readmission date of 06/08/15 with diagnoses which included Urinary Tract Infections, Urinary Retention, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) dated 04/21/15, revealed the facility assessed the resident as having short/long term memory loss.</p> <p>Observation, on 06/17/15 at 8:45 AM, revealed Resident #10 sitting in his/her wheelchair in the television area with the urinary catheter tubing laying on the floor under his/her wheelchair. State Agency Surveyor showed CNA #11 the catheter tubing on the floor and CNA #11 corrected the problem by removing the urinary tubing from the floor. Interview with CNA #11 on 6/17/15 at 8:45 AM, revealed the urinary catheter tubing should not have been on the floor due to germs and bacteria on the floor.</p> <p>Observation on 06/19/15 at 5:00 PM revealed Resident #10 sitting in his/her wheelchair in the hall with the urinary catheter tubing laying on the</p>	F441	<p>The policy and procedure on Nursing Infection Control Procedures was reviewed on 6/22/15 by the Infection Control Nurse and DON and was determined to remain appropriate.</p> <p>Resident #10 was audited by the Infection Control nurse on 6/19/15 and was determined to have no negative effects from the catheter bag having been on the floor.</p> <p>CNA #11 was inserviced by the nurse manager on 6/17/15 about the proper infection control procedure related to catheter bags not being on the floor.</p>	
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F441	<p>1. Continued From page 49 floor under his/her wheelchair. Interview with Unit Manager #3 and observation of Resident #10 on 6/19/15 at 5:05 PM, revealed the catheter tubing should not be touching the floor because of infection control.</p> <p>3. Review of the facility's "Catheter Care" policy and procedure, revised 11/19/11, revealed care would be provided to residents with the presence of urinary catheters in a manner that would minimize risks of complications. The procedure stated "do not hold catheter bag above bladder level". To minimize the risk of cross contamination, do not handle any equipment such as door knobs, call lights, or Resident's personal belongings with gloves. Wash your hands. Wearing gloves does not mean you don't have to wash your hands.</p> <p>Review of the facility's "Catheter Irrigation" policy and procedure, undated, revealed the nurse was to disconnect the catheter from the drainage tubing and cover the open end of the drainage tubing with a protector cap. Next, insert the syringe into the catheter opening and slowly instill the Normal Saline. Remove the syringe and allow the solution to drain into the collection basin. Repeat as necessary until flow returns easily. Remove the protector cap, clean the end of the drainage tubing with alcohol swab and reconnect to catheter.</p> <p>Observation on 06/18/15 at 3:40 PM of Resident #10 receiving catheter irrigation performed by LPN #1, revealed the nurse disconnected the indwelling urinary catheter from the urinary drainage tubing and irrigated the indwelling urinary catheter with fifty (50) milliliters (ml) of Normal Saline (NS) with a syringe. After irrigating</p>	F441	<p>The policy and procedure on Catheter Care was reviewed by the DON on 6/19/15 and was determined to remain appropriate.</p> <p>The policy and procedure on Catheter Irrigation was reviewed by the DON on 6/18/15 and was determined to remain appropriate.</p> <p>On 6/18/15, LPN #1 was inserviced by the nurse manager on the proper procedure for irrigating a catheter to include draining irrigation solution into a basin.</p>	

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F441	<p>Continued From page 50</p> <p>with the NS he reattached the catheter to the urinary drainage tubing to allow NS to drain back into the urinary bag, instead of utilizing a basin per facility policy. LPN #1 repeated this procedure again; however, this time a new urinary bag was attached, after he/she sent the Certified Nursing Assistant (CNA) out of the room to find a new bag. LPN #1 was noted to lift the urinary bag higher than the Resident #10's bladder to show the surveyor the urine in the bag. After finishing the procedure, he left the contaminated gloves on and touched the side rail and lowered the bed using the bed control.</p> <p>Interview with LPN #1, on 06/18/15 at 4:05 PM, revealed he could not ensure that one hundred (100) cc's was returned during urinary catheter irrigation after irrigating and allowing the fluid to drain back into the used urinary drainage bag which already contained urine. He stated he had not been taught to empty the urine into a basin during irrigation, and had not been observed performing catheter irrigations since in nursing school which was years ago. Further interview revealed he could see how it was an infection control concern to raise the urinary catheter bag above the resident's bladder. LPN #1 also explained, gloves should have been removed and hands washed before touching the side rail and bed control after performing the catheter irrigation.</p> <p>Interview with the DON, on 06/19/15 at 1:35 PM, revealed that urinary catheter tubing should not be on the floor. She Stated during urinary catheter irrigation that urine was supposed to flow into a basin and bag should be changed and the urinary bag should not have lifted higher than the resident. She further stated that hands should</p>	F441	<p>On 6/18/15 LPN #1 was inserviced by the nurse manager on the infection control issues of raising the catheter bag above the level of the bladder. LPN #1 indicated that the catheter bag was not attached to the catheter at the time this occurred. LPN #1 was also instructed on proper infection control related to changing of soiled gloves prior to touching other objects to avoid contamination.</p> <p>LPN #1 was also inserviced on 6/18/15 by the nurse manager on the purpose of allowing the irrigation solution to drain into a basin for measuring purposes to ensure the solution had drained properly, as opposed to hooking it up to the catheter bag.</p>	

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F441	<p>Continued From page 51</p> <p>have been washed prior to touching the control on the bed.</p> <p>4. Review of the facility "Review of Nursing Infection Control Procedures", undated, revealed the easiest and most effective way to minimize the spread of infection was by proper handwashing. Hands should be washed after removing gloves. When providing perineal care to a resident remember if a male is uncircumcised, retract the foreskin before cleaning then return it to its natural position after the procedure.</p> <p>Observation, on 6/18/15 at 3:55 PM, revealed CNA #1 performed catheter care on Resident #10 who was uncircumcised. While CNA #1 performed the catheter care, it was noted that she retracted the foreskin of the penis and did not return the foreskin to the normal placement after the procedure was finished. It was also noted the CNA bagged the soiled linens after the procedure, removed her gloves, and exited the room without washing her hands.</p> <p>Interview with CNA #1, on 06/18/15 at 3:55 PM, revealed she thought Resident #10 was circumcised, although she stated the foreskin was pulled back and she thought the foreskin was placed back into the original position. Further interview, revealed she thought her hands were washed prior to exiting the room; however, the two (2) surveyors observing the procedure did not observe handwashing prior to exiting the room.</p> <p>Interview with DON, on 06/19/15 at 1:35 PM, revealed CNA #1 should have pulled skin back down over penis and washed his/her hands prior to leaving the resident's room.</p>	F441	<p>The policy and procedure on Nursing Infection Control Procedures was reviewed on 6/22/15 by the DON and was determined to remain appropriate.</p> <p>CNA #1 was inserviced by the Nurse Manager on 6/18/15 on proper infection control procedures related to retraction of foreskin and changing of soiled gloves and washing of hands to prevent cross contamination.</p> <p>Resident #10 was assessed by the nurse manager on 6/18/15 and was noted to have no ill effects from the catheter care procedure.</p>	

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F441	<p>Continued From page 52</p> <p>5. Review of the facility's "Review of Nursing Infection Control Procedures", undated, revealed Oxygen/HHN equipment should be kept bagged when not in use and all tubings must be kept off the floor.</p> <p>Observation, on 06/16/15 at 10:05 AM, during initial tour revealed Oxygen tubing and nasal cannula's not bagged in two (2) rooms, room #241A and #241B, and Hand Held Nebulizer (HHN) tubing and mouthpiece not bagged in two (2) rooms, rooms #234A and #235B.</p> <p>Interview with Unit Manager #3, on 6/16/15 at 11:00 AM, revealed Oxygen tubing, nasal cannula's and HHN tubing with masks or mouthpieces should be bagged due to infection control issues.</p> <p>Interview with DON, on 06/19/15 at 1:35 PM, revealed that Oxygen tubing and nasal cannula's and HHN's tubing, masks, and mouthpieces should be bagged when not use.</p> <p>6. Review of facility's policy titled "Clostridium Difficile (C-Diff)" undated, revealed the facility was to prevent transmission of clostridium difficile in the long term care facility. The procedure for prevention was noted with general measures to alert the Administrator, Director of Nursing (DON), Infection Control Nurse (ICN) and the Infection Control Committee (ICC) to any case of C-Diff. Surveillance data was to be maintained on cases of C-Diff infection and continued education to limit the spread of infection. In addition facility procedure called for the following: isolation Precautions by which residents with diarrhea caused by C-Diff should be in private rooms or in the same room with other residents</p>	F441	<p>An audit was completed on 6/17/15 by the nurse managers of all oxygen administration devices, including HHN tubing to ensure that all tubings were changed, dated, and secured according to our policy.</p> <p>Residents in 234-1 and 234-2 oxygen tubing was changed and placed in bags by the nurse manager on 6/16/15. The HHN tubing and mouthpiece for resident 234-1 and 235-2 was changed and placed in bags by the nurse manager on 6/16/15. These residents were assessed by the nurse manager on 6/16/15 and were determined to have no ill effects from the tubing having not been in bags.</p> <p>The policy and procedure on Clostridium Difficile (C-Diff) was reviewed by the DON on 7/13/15 and was updated to include room assignments for residents with C-Diff, cleaning procedures to follow when a resident has C-Diff and clarifications on when and what type of PPE is required.</p>	

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F441	<p>Continued From page 53</p> <p>with C-Diff; gloves should be worn to enter the room of the resident who had diarrhea caused by C-Diff; A gown was needed to enter the room of a resident who had diarrhea caused by C-Diff if substantial contact with the resident or environmental surfaces was anticipated; gowns and gloves should be removed before leaving the resident's room and hands must be washed immediately with an antiseptic soap; items such as stethoscope, sphygmomanometer, and thermometer should be dedicated to use on that resident only or a cohort of residents with C-Diff; and isolation may be discontinued once diarrhea has ceased.</p> <p>Further review of facility policy titled "Contact Precautions" undated revealed it was the facility's intent to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Contact Precautions were to be used in addition to Standard Precautions for residents with infections that could be easily transmitted by direct and indirect contact. The following areas were stated to be expected of the facility:</p> <p>a) Resident Placement-residents were to be placed in a private room and when a private room was not available and cohorting was not an option, the facility was to consider the organism and resident population when placement was determined.</p> <p>b) Gloves and Handwashing-Gloves are worn when the room is entered and care is provided to the resident. The gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage). The gloves</p>	F441	The Contact Precautions policy and procedure was updated by the DON on 7/13/15 to reflect that resident's can cohabitate when certain criteria are met.	

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F441	<p>11 Continued From page 54</p> <p>should be removed before leaving the resident's room and hands should be washed immediately. After glove removal and handwashing, hands should not touch potentially contaminated environmental surfaces or items.</p> <p>c) Gowns-gowns should be worn when entering room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent or would drainage is not contained by a dressing. If a gown is worn, it should be removed before leaving the resident's room. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces.</p> <p>d) Resident Transport-activities of the resident may need to be limited. This will be determined on a case by case basis. If the resident leaves the room, precautions should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.</p> <p>e) Resident Care Equipment-dedicated resident care equipment should be considered for the resident. If use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident.</p> <p>Observation of Resident #16 in his/her room, on 06/16/15 at 10:45 AM, revealed a sign on the door which stated "Listed Infections and Conditions Requiring Contact Precautions". Interview with CNA #10 at the time of the observation revealed the sign might be related to</p>	F441	<p>The Contact Precautions policy and procedure was updated by the DON on 7/13/15 to reflect what type of PPE should be worn under specific circumstances.</p> <p>The Contact Precautions policy and procedure was reviewed by the DON on 7/13/15 and the section on Resident Transport was determined to remain appropriate.</p> <p>The Contact Precautions policy and procedure was reviewed by the DON on 7/13/15 and the section on Resident Care Equipment was determined to remain appropriate.</p> <p>The sign on Resident #16's door was replaced by the nurse manager on 6/18/15 with a sign that read "Please See Nurse Before Entering"</p> <p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #10 not only through report during the shift change huddle, but also via the Point of Care (POC) system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #10, reflected that this resident was under contact precautions.</p>	
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NAME OF PROVIDER OR SUPPLIER  ROSEDALE GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015
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F441	<p>Continued From page 55</p> <p>contact precautions; however, she was not aware if the resident was considered to have contact precautions.</p> <p>Additional observation made of the resident's room, on 06/17/15 at 8:50 AM, revealed a sign which stated "Listed Infections and Conditions Requiring Contact Precautions". The resident's bed had been stripped and was unmade and the sign on the bathroom door indicated the family would do the resident's laundry "Do Not Send Down". There was no PPE items in the residents room or at the door and the resident's personal clothing was observed to be in a clothing basket unbagged. The resident was not present in the room.</p> <p>Review of the clinical record for Resident #16 revealed the facility readmitted the resident on 06/09/15 with diagnoses which included C-Diff, Diarrhea, Urinary Incontinence and Debility. Review Resident #26's Admission Minimum Data Set (MDS) Assessment dated 05/28/15 revealed the resident was assessed to be Frequently Incontinent of Bowel and Occasionally Incontinent of Bladder and was not on a toileting program. Additional review of the resident's Vitals Report dated 06/17/15 for Bowel Movements, revealed the resident had episodes of "Loose" to "Liquid" consistent stools on 06/12/15 at 7:15 AM Continent Loose Consistency, 06/12/15 at 11:50 AM Continent Loose Consistency, 06/15/15 at 5:52 PM Continent Loose Consistency and 06/16/15 at 4:22 PM Incontinent Loose-Liquid Consistency. There was no documented evidence that the Physician was notified when the resident's symptoms returned for possible C-Diff.</p> <p>Interview with CNA #12, on 06/16/15 at 4:52 PM,</p>	F441	<p>PPE was available to staff in the nurse's nook. On 6/17/15 the laundry was placed in a bag by the nursing assistant.</p> <p>With regards to Resident #16, upon readmission to the facility on 6/9/15, the hospital had discontinued her treatment with Flagyl. However, due to her history, the facility physician ordered Flagyl 250mg bid x 10 days then Flagyl 250 mg x 10 days for loose stools as a precautionary measure. From the most recent admission to the facility on 5/21/15, this resident has been treated for C-Diff and has had varying consistencies and frequencies of her bowel movements, including continent and incontinent episodes. The physician was contacted on 6/19/15 by the charge nurse and verbalized he did not consider this a change in condition and ordered a stool test for C-Diff. Although the resident continued to have loose stools, the result on 6/21/15 was negative for C-Diff. The physician was notified and orders given to continue with the current treatment orders until finished.</p>	

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F441	<p>Continued From page 56</p> <p>revealed she was not sure if the resident was under contact precautions. She stated the facility's process was to "suit up" when you assisted the resident to the bathroom, otherwise you would use gloves. She stated the PPE equipment should be at the door of the resident's room. She further stated she had not worn a protective gown when she assisted the resident to the toilet. She stated she just found out Resident #16 had C-Diff on 06/16/15.</p> <p>Interview with Nurse Manager #4, on 06/16/15 at 4:58 PM, revealed a gown should be worn when a resident had "explosive bowel". She stated Resident #16 was under contact precautions, however, he/she did not actively have diarrhea. She stated the nurse manager's put contact precautions on the door and notify staff in the "huddle room" of the resident's condition. She stated the resident was not actively infected but was still taking Flagyl.</p> <p>Interview with the Assistant Director of Nursing (ADON), who also served as the Infection Control Nurse, on 06/16/15 at 5:13 PM revealed the resident came to the facility with active C-Diff. She stated the resident was put on contact precautions and all staff were notified in the facility "Huddle" meeting. She stated Resident #16 no longer needed contact precautions, but standard precautions, because he/she was without active diarrhea. She stated the regular standard precautions were due to the resident's use of Flagyl. She stated the facility's process in the care for the resident was to wash hands and wear gloves. She concluded that the only time staff were to wear a gown was when the resident was incontinent or if soiling had occurred. She stated if the resident had active diarrhea, staff</p>	F441	<p>With regards to resident #16, the fact that the resident had a diagnosis of C-Diff was shared with CNA #12 not only through report during the shift change huddle, but also via the POC system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #12, reflected that this resident was under contact precautions.</p>	
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F441	<p>1. Continued From page 57 should wear a gown when assisted to the toilet.</p> <p>Further interview with the ADON on 06/17/15 at 5:41 PM revealed to her knowledge the family had not been educated with regard to the resident's current symptoms of C-Diff. She also stated she had not been informed that the resident's symptoms had returned. She stated the physician should have been notified to continue with contact precautions and the family should have been notified with regard to laundry care. She stated PPE items should have been placed in the vicinity or outside the door of the resident. She stated based on the observed Bowel Movement report the resident may still have C-Diff. She stated the nurse aide failed to follow the facility process for contact precautions as it related to C-Diff and the care of Resident #16. She also stated the facility failed in its process to notify her when the symptoms of C-Diff returned for Resident #16 as well as failure to notify the physician when the symptoms returned. She concluded the concern for the resident and the other resident's was the possibility of infection due to contact of C-Diff should the resident have an episode in their presence outside of his/her room.</p> <p>Interview with the DON on 06/17/15 at 6:13 PM revealed she was uncertain if the family had been made aware of Resident #16's returned symptoms of C-Diff or the need for precautionary measure when the resident's laundry was cleaned. She agreed that the facility failed to notify the physician of the resident's returned symptoms for C-Diff. She stated it was her expectation that the resident receive additional testing at the point of returned symptoms. She stated facility staff should have reported when</p>	F441	<p>The nurse manager reminded the resident's family of the C-Diff symptoms and handling of linens on 6/17/15. The family verbalized that they were aware.</p>	
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F441	<p>Continued From page 58</p> <p>changes occurred for Resident #16 and the nurses should have asked questions with regard to the Vitals Report for Bowel Movements upon review. The Nurse Manager, the MDS Nurse and the Charge Nurse should have been aware that the resident's symptoms had returned and the nurse should have notified the physician. She stated the facility failed in its process for contact precautions as it related to C-Diff. She concluded she could not state the staff washed the resident's hands before he/she was escorted from his/her room for meals, due to their statements that they were not aware of the Resident's need for contact precautions as they related to C-Diff.</p> <p>7. Review of Resident #26's medical record revealed the facility admitted the resident on 05/30/15 and re-admitted the resident on 06/13/15 with diagnoses which included Debility, and Osteoarthritis. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/15/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a eight (8) out of fifteen (15) indicating cognitive impairment.</p> <p>Review of the Resident Progress Notes dated 06/16/15, at 8:17 PM, revealed the resident had foul smelling loose bowel movement (BM), the Physician was notified and orders were received to send a stool out for testing for Clostridium Difficile (C-Diff) (a very contagious bacterial organism that causes an infection of the intestinal tract).</p> <p>Review of the laboratory data revealed a specimen was collected on 06/17/15 and was reported on 06/17/15 as C. Diff positive.</p>	F441		
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F441	<p>1 Continued From page 59</p> <p>Further review of the Resident Progress Notes, dated 06/17/15 at 5:36 PM, revealed the resident had positive results for C-Diff, and a message was left for the Physician. Review of the Notes dated 06/17/15 at 6:38 PM, revealed a message was received from the Physician related to the positive C-Diff results with new orders received for Flagyl 500 milligrams (mg) three (3) times a day for ten (10) days (antibiotic medication), Florastor 250 mg two (2) times a day for ten (10) days (probiotic) and to place the resident in contact isolation until loose stool resolves.</p> <p>Review of the Comprehensive Plan of Care dated 06/01/15, revealed there was no documented evidence the Care Plan was revised related to the resident's diagnosis of C-Diff and the need for contact precautions.</p> <p>Observation, on 06/18/15 at 5:10 PM, revealed there was no signage on the resident's door to alert staff, visitors, and family of the need to see the nurse before entering the room. In addition, there was no personal protective equipment (gloves, gowns) outside the door accessible for use or any biohazard bins inside the room.</p> <p>Interview with CNA #14, on 06/18/15 at 5:10 PM, revealed she was assigned to Resident #26 and had been assigned since 7:00 AM that morning. She stated she was aware the resident had C-Diff and was to be in contact isolation and she was to use contact precautions. She further stated the contact precautions was the same as standard precautions and she would need to wear gloves when caring for the resident and would only need to wear a gown if she felt the need such as if the resident was incontinent of stool. She further</p>	F441	<p>With regards to Resident #26, the plan of care was reviewed and updated on 6/17/15 to reflect the diagnosis of C-Diff. The plan of care was, again, reviewed and updated to reflect contact precautions on 6/18/15 by the MDS nurse as the official positive report was received on 6/17/15 at 5:20 pm.</p> <p>A sign stating "See Nurse Before Entering" was placed on the door by the Nurse Manager on 6/18/15. Personal Protective equipment was available at all times in the nurse's nook and was accessible for use.</p> <p>On 6/18/15 the MDS nurse for Resident #26 was inserviced by the DON on the need to update the plan of care to reflect contact precautions for C-Diff and other MDRO's.</p> <p>All MDS nurses were educated on 6/18/15 by the DON of the need to update the plan of care to reflect the diagnoses of C-Diff and MDRO's to include the diagnoses and need for contact precautions.</p> <p>With regards to resident #26, the fact that the resident had a diagnosis of C-Diff was shared with CNA #14 not only through report during the shift change huddle, but also via the Point of Care (POC) system (this includes resident Profile, the resident plan of care, as well as the diagnoses list). Nursing assistants access and utilize these resources each shift to determine each resident's care needs. The care plan, which was available to CNA #14, reflected that this resident had C-Diff.</p>	

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F441	<p>Continued From page 60</p> <p>stated the resident was incontinent and was unable to tell when she/he needed to urinate. However, she stated the resident would ask for a bed pan when she/he needed to have a bowel movement. Continued interview revealed she had changed the resident's brief throughout the day, and had made her/his bed, changed the bed linens, and had transferred the resident to a wheelchair and had not worn a gown because the resident had no bowel movements. She stated if she went to change the resident's brief and noted the resident had a bowel movement, she would need to come to the Nurse Managers office to obtain a gown and then go back and finish providing care to the resident. Further interview revealed after reviewing the CNA Care Plan, there was no contact precautions noted to alert the CNA's. She stated she knew the resident had C-Diff from the morning report which she received from the nurse and also she received report from the CNA who was going off duty.</p> <p>Interview on 06/18/15 at 5:25 PM with RN #2, revealed she was assigned to Resident #26 and the resident was on contact isolation precautions for C-Diff. She stated the resident was receiving Flagyl (antibiotic medication) and the staff was to wear gloves when caring for the resident as well as gowns if the resident had explosive diarrhea or if there was a large amount of stool and would also need to wear a gown to make the bed and change bed linens. However, she stated staff would not need to wear a gown just for incontinence care if there was not a lot of stool. Continued interview revealed there should be signage on the door stating "see nurse before entering" to alert visitors, staff, family of the precautions needed. She stated visitors would need to wear a gown if they went in to visit and</p>	F441	All staff will be inserviced by the department director, supervisor, staff development nurse, nurse manager, MDS nurse, charge nurse or ADON as of 7/31/15 regarding the policy for contact precautions, including the need for signs on the door and the location of PPE.	
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F441	<p>Continued From page 61</p> <p>sat down and were at risk if there was no signage on the door.</p> <p>Interview with the Infection Control Nurse on 06/17/15 at 3:00 PM revealed if a resident had the diagnosis of C-Diff and was being treated for C-Diff, there would need to be a sign on the door to see the nurse before entering or a contact isolation sign. She stated every worker had access to PPE and if staff was using PPE a lot, they would need to have the PPE outside the door accessible for staff.</p> <p>Continued interview with the ICN on 06/19/15 at 11:30 AM, revealed Resident #26 was diagnosed with C-Diff and they were to use standard precautions; however, if there was loose stools this would indicate the need for a different type of precaution. She stated C-Diff could live on surfaces and could be easily transmitted in the environment and she was unsure why there was signage for some residents with C-Diff and no signage for other residents with C-Diff in the facility. She stated she could not answer if there should be signs up to alert staff and visitors of precautions to see the nurse before entering or contact precautions related to C-Diff and at this point there was no policy for signage. Continued interview revealed, personally she would wear a gown if a resident was having diarrhea, or if she had to change bed linens or if she had to come into contact with a contaminated surfaces because C-Diff could live on surfaces such as side rails. She stated there was no audits to ensure staff were using proper precautions for residents with MDRO and C-Diff. She further stated they may need to "re-look" at the policy for contact isolation and she would feel more comfortable doing more research.</p>	F441	<p>The Infection Control Nurse was inserviced by the DON on 6/19/15 on the Infection Control policy related to signage on the resident room door and that the signs stating "Please See Nurse Before Entering" were to be placed for resident's with C-Diff and MDRO's.</p>	
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F441	Continued From page 62  Interview with the DON on 06/19/15 at 1:30 PM, revealed she had training related to infection control; however, the ICN received most of the training. Shes stated for any MDRO and C-Diff, there should be signage on the door to alert family and visitors to check with the nurse before entering. She further stated staff were aware of the residents who had MDRO through shift to shift report. Continued interview revealed gowns were available for use and kept at the nurses station and she did not think it was necessary to always wear a gown for incontinence care or changing bed linens for a resident with C-Diff ;however, review of the facility "Contact Precautions" Policy, revealed a gown was needed to enter the room of a resident who had diarrhea caused by C-Diff if substantial contact with the resident or environmental surfaces was anticipated. Further interview revealed Resident #26's Comprehensive Plan of Care should have been revised related to the resident's diagnosis of C-Diff and the need for contact precautions.  8. Review of the facility's policy titled, "Hand Washing/Sanitizing/Glove use", revealed routine hand washing reduced the number of bacteria on the surface of the skin and is the single most effective procedure in preventing the spread of infection. Even when gloves are worn, it is still extremely important to wash your hands each time gloves are removed. Gloves may have or may receive tiny perforations during a procedure, allowing bacteria to reach your skin and rapidly multiply on your hands. Touching residents or other items with soiled gloves will surely spread the bacteria, and the person most likely to next handle that contaminated item and pick up the bacteria is the person who touched it with soiled	F441	The policy and procedure for handwashing was reviewed by the DON on 6/19/15 and was determined to remain appropriate.	
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F441	<p>#1 Continued From page 63</p> <p>gloves. The policy recommends washing hands before and after significant contact with a resident, such as providing personal care, where contact with body fluids or mucous membranes is likely to occur.</p> <p>Record review revealed Resident #1 was admitted by the facility on 04/27/07 with diagnoses which included Anemia, Hypertension, Peripheral Vascular Disease, Gastroesophageal Reflux, Hypothyroid, and Chronic Kidney Disease (Stage III). Resident #1's most recent hospitalization was on 06/11/15, when he/she had been experiencing a gradual decline over the last few months and had recently changed his/her code status to a Do Not Resuscitate after the last hospitalization.</p> <p>An observation of a skin assessment conducted on Resident # 1, on 06/19/15 at 10:15 AM by RN #4 revealed he/she washed and gloved their hands prior to the skin assessment. RN #4 began the skin assessment at the head and proceeded down the body to the perineal/rectal area, where he/she opened Resident #1's incontinence brief on the posterior aspect and touched Resident #1's rectal area, closed the incontinence brief and proceeded to a clean area and touched Resident #1's left arm and back. RN #4 repositioned Resident #1 in the bed, touching the clean area of clothes and linen and opened the incontinent brief on the anterior aspect and touched the resident's perineal area. RN #4 was observed to close the incontinence brief, reposition Resident #1 in bed and then removed her gloves and washed her hands with alcohol wash. RN #4 was observed to move from a dirty area to a clean area twice during the skin assessment without changing gloves and</p>	F441	<p>RN # 4 was educated on 6/19/15 by the nurse manager on the handwashing policy and the expectation that gloves be changed after soiled before touching clean areas / items.</p> <p>Resident #1 was observed by the nurse manager on 6/19/15 and was determined to have no negative effects from the gloves not having been changed.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  06/19/2015
NAME OF PROVIDER OR SUPPLIER  ROSEDALE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	
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F441	<p>1 Continued From page 64</p> <p>washing his/her hands, thereby contaminating the resident and their clothing and linen.</p> <p>An interview conducted on 06/19/15 at 10:30 am with RN #4 revealed he/she was not aware that they had crossed from a dirty to clean area during the head to toe skin assessment of Resident #1. RN #4 revealed he/she was knowledgeable regarding the importance of infection control and good hand washing and gloving technique and he/she felt nervous because they were being watched and forgot to follow the proper procedure to prevent the spread of infection.</p> <p>An interview conducted on 06/19/15 at 10:45 AM with RN #1, the nursing supervisor of RN #4, which revealed all nursing staff received training during orientation and throughout the year on infection control and the importance of preventing the spread to infection. RN #1 related that he/she conducted Quality Assurance (QA) audits on the nursing staff to ensure Infection Control policies and procedures were being followed. RN #1 revealed it was his/her expectation that all of the nursing staff follow the facility policy for hand washing and gloving during resident care to prevent the spread of infection.</p> <p>An interview conducted on 06/19/15 at 2:50 pm with the DON revealed it was her expectation that all nursing staff follow the recommended policy of hand washing and gloving technique. The DON stated RN #4 should have changed his/her gloves and washed their hands when going from a dirty to clean area at all times during the care of a resident.</p> <p>9. Review of the medical record revealed Resident #6 was admitted by the facility on</p>	F441		

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F441	<p>Continued From page 65</p> <p>06/21/11 with diagnoses which included Anemia, Debility, Alzheimer's Disease, Diabetes, Chronic Kidney Disease, Chronic Heart Failure, and Right Side Hemiplegia (Weakness of the entire right side of the body). Review of the resident's June 2015 monthly Physician Orders revealed the resident had wound treatment orders to paint the right lateral ankle with Betadine twice daily and cover the site with a dry dressing.</p> <p>Observation of wound care to Resident #6, on 06/17/15 at 11:15 AM, by LPN #5 revealed during the wound treatment procedure LPN #5 placed the new dry dressing on the resident's bedside chest with no barrier prior to using the dressing to cover the wound.</p> <p>Interview, on 06/17/15 at 1:41 PM, with LPN #5 regarding the wound treatment procedure revealed she was not supposed to place the dressing on the bedside chest because it was an infection control issue. The LPN revealed by not providing a barrier there was potential of cross contamination of organisms.</p> <p>Interview, on 06/19/15 at 11:30 AM, with the Infection Control Nurse revealed when the nurse performed the dressing change, the new dressing was supposed to be placed on a barrier and not the bedside chest because there was a risk of contamination of the dressing/wound.</p> <p>Interview, on 06/19/15 at 1:30 PM, with the DON revealed during the dressing change the nurse was to place the new dressing on a drape (barrier) and not on the bare table.</p>	F441	<p>With regards to LPN #5, she was inserviced on 6/17/15 by the nurse manager on the proper infection control techniques to follow during a dressing change.</p> <p>Resident #6 was assessed by the nurse manager on 6/17/15 and was determined to have no ill effects from the dressing change.</p> <p>All staff will be inserviced by the department director, supervisor, staff development nurse, nurse manager, MDS nurse, charge nurse or ADON as of 7/31/15 regarding the policy for infection control, including the need for signs on the door and the location of PPE.</p> <p>All MDS nurses were educated on 6/18/15 by the DON of the need to update the plan of care to reflect the diagnoses of C-Diff and MDRO's to include the diagnoses and need for contact precautions.</p> <p>All residents who require contact isolation, have indwelling urinary catheters, require dressing changes, receive oxygen or HHN treatments, or use the whirlpool tubs have the potential to be affected.</p> <p>As of 6/18/15, an audit was completed by nurse managers of all residents requiring contact isolation and signs were posted and care plans were reviewed and updated to include the need for contact precautions.</p>	
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F441		F441	<p>On 6/19/15, the nurse managers completed an audit of all residents with indwelling urinary catheters to ensure that their catheter bags were not touching the floor. No residents had negative outcomes as a result.</p> <p>On 6/19/15, the nurse managers completed an audit of all residents receiving dressing changes to assess for potential negative outcomes; none were noted.</p> <p>An audit was completed on 6/17/15 by the nurse managers of all oxygen administration devices, including HHN tubing to ensure that all tubings were changed, dated, and secured according to our policy.</p> <p>An audit was completed by the Infection Control nurse on 6/19/15 of residents #3, #7, #9, #10, #27, and A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, AND P and no issues were noted with cross contamination.</p> <p>Quality assurance monitoring will be done as follows:</p> <ul style="list-style-type: none"> <li>• disinfecting of whirlpool tubs, catheter care (to include location of catheter tubing), proper storage of oxygen and HHN tubing, changing of gloves, and use of PPE <ul style="list-style-type: none"> <li>○ monitoring to be completed daily x 2 weeks by the nurse manager, central supply coordinator, nursing supervisor or ADON beginning 7/20/15</li> <li>○ Monitoring will then be done weekly x 6 weeks by the nurse manager, central supply coordinator, nursing supervisor or ADON</li> </ul> </li> </ul>	

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F441		F441	<ul style="list-style-type: none"> <li>○ Monitoring will then occur monthly x 4 months by the nurse manager, central supply coordinator, nursing supervisor or ADON</li> <li>○ Monitoring will then occur quarterly x2 by the nurse manager, central supply coordinator, nursing supervisor or ADON</li> <li>• Irrigation of catheters, dressing changes               <ul style="list-style-type: none"> <li>○ Monitoring will be done weekly x 4 weeks by the nurse manager, nursing supervisor or ADON beginning 7/20/15</li> <li>○ Monitoring will then occur monthly x 2 months by the nurse manager, nursing supervisor or ADON</li> <li>○ Monitoring will then occur quarterly x3 by the nurse manager, nursing supervisor or ADON</li> </ul> </li> </ul> <p>The ADON/QA Nurse will provide the DON a summary of the audit information on a monthly basis, in conjunction with the QA/PI process.</p> <p>This facility has QA/PI meetings monthly. Audits concerning Infection Control will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.</p> <p>The Infection Control Nurse and Director of Nursing are responsible to ensure compliance with infection control standards. Compliance with Infection Control will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.</p>	

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(X4) ID PREFIX TAG K000	SUMMARY OF STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 8/3/2015
	<p>0. INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Seventeen (17) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 06/16/15 and concluded on 06/16/15. Rosedale Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two hundred ten (210) beds with a census of one hundred ninety-two (192) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>		<p><b>PLAN OF CORRECTION:</b></p> <p>The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.</p>	



*Sonda Knoeliman*

*Administrative*

*7/17/15*

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K000	Continued From page 1 Fire)	K000		
K062 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler heads were not obstructed, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seventeen (17) smoke compartments, and staff.</p> <p>The findings include:</p> <p>Observation, on 06/16/15 at 4:18 PM, with the Maintenance Director, revealed the basement overhead doors obstructed three (3) sprinkler heads while in the raised position. Interview, at the time of observation, with the Maintenance Director, revealed he had never identified the automatic sprinkler as being obstructed.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.3.1 Sprinklers shall be installed under fixed obstructions over 4 ft (1.2 m) wide such as ducts, decks, open grate flooring, cutting tables, and</p>	K062	<p>NFPA 101 LIFE SAFETY CODE STANDARD. Rosedale Green is committed to comply with the requirement for automatic sprinkler systems that are continuously maintained in reliable operating conditions and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NPFA 25, 9.7.5</p> <p>On 6/16/2015 upon identifying that three (3) sprinkler heads were obstructed in the facility garage when the overhead doors were in the raised position, the Maintenance Director contacted the facility's Sprinkler Vendor. The vendor was requested to adjust the sprinkler heads so they would not longer be obstructed when the overhead door was raised. The sprinkler vendor, completed this work on 6/22/15.</p> <p>An audit was completed by 7/17/2015 by the Environmental Services Department of the entire facility to ensure other areas, such as ducts, decks, open grate flooring, cutting tables, and overhead doors over 4 ft. wide did not obstruct the sprinklers.</p> <p>An audit will also be completed by the Sprinkler Vendor prior to 7/31/2015 to ensure all areas of the facility meet the requirements of NFPA 13. If any additional areas are identified, the vendor will install or adjust sprinklers as necessary prior to 8/3/15.</p> <p>The audits will be communicated with the Administrator by 8/3/15, as well as the QA/PI committee at the August monthly meeting.</p> <p>On-going compliance with sprinkler installation is the responsibility of the Environmental Services Director.</p>	8/3/2015

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K062	Continued From page 2 overhead doors.	K062		
K064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seventeen (17) smoke compartments, twenty six (26) residents, staff and visitors.  The findings included:  Observation on 06/16/15 at 2:03 PM, with the Maintenance Director, revealed near room 245N a fire extinguisher with a verification of service collar dated May 2009. Interview, at the time of observation, with the Maintenance Director, revealed he was not aware the fire extinguisher did not have a current verification of service collar.  Reference: NFPA 10 (1998 Edition)  4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance	K064	NFPA 101 LIFE SAFETY CODE STANDARD. Rosedale Green is committed to comply with NFPA 10, 9.7.4.1, 19.3.5.6, portable fire extinguishers are provided in all health care occupancies.  When one (1) of the forty six (45) fire extinguishers located within Rosedale Green on 6/16/15 was noted to have a collar dated May 2009, the Maintenance Director contacted the facility's Fire Extinguisher Vendor to determine the rationale for why this collar appeared to have missed the 6 year maintenance check by 16 days.  The Fire Extinguisher Vendor conducted an inspection on the fire extinguisher in question on 6/17/15. The Vendor indicated that a yearly audit is conducted on all extinguishers in December to ensure that all of the extinguishers meet the requirements of NFPA 10. This audit was conducted in December 2014.  An audit was completed on 7/15/2015 by the Fire Extinguisher Vendor of the entire facility to ensure all fire extinguishers were in compliance with the applicable NFPA standards. The Fire Extinguisher Vendor will now move their yearly maintenance and audit of the fire extinguishers from December to June, in order to ensure we maintain the appropriate and current verification.  An audit will also be completed by the Maintenance Director to verify that all the facility fire extinguishers have a current verification of service collar, this will be completed by 7/17/2015.	8/3/2015

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K064	Continued From page 3 procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. Exception; Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. 4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in. (5.1 cm x 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance 4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size	K064	The audits will be communicated with the Administrator by 7/31/15, as well as the QA/PI committee at the August monthly meeting.  On-going compliance with fire extinguisher verification of service is the responsibility of the Environmental Services Director.	

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K064	Continued From page 4 that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.	K064		