

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2013
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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 02/05/13 and concluded on 02/10/13. No substandard quality of care was identified; however, deficiencies were cited with the highest Scope and Severity S/S being an "F".	F 000	F241 Dignity and Respect of Individuality The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 care was provided in a manner and an environment that maintained each resident's dignity, for one (1) of twenty-four (24) sampled residents (Resident #16) and two (2) unsampled residents. Resident #16 was observed in the hall without a dignity bag or other cover over the catheter drainage bag. In addition, two (2) unsampled residents in the Long Term Care (LTC) dining room were fed by staff who were standing over the residents. The findings include: 1. Observation, on 02/06/13 at 4:25 PM, revealed Resident #16 was in the hall, in his/her motorized wheelchair, without a catheter privacy bag. Interview, on 02/06/13 at 4:30 PM, with	F 241	1.1 Unit Manager immediately obtained a dignity bag and placed on resident #16 motorized W/C to cover the catheter bag on 2/6/2013. 1) Interview with resident #16 conducted by Unit Manager on 2/6/13 revealed that Resident #16 showed no ill effects from the alleged deficient practice. 2) A facility audit was conducted by DON, Unit Manager and Clinical Coordinator on 2/11/2013, 2/12/2013 and 2/13/2013 to ensure all residents with a catheter also had a dignity bag and/or cover and that all other resident's dignity was maintained. 3) DON updated catheter policy to include covering drainage bag with dignity bags. 4) RNs, LPNs, SRNAs were in serviced by DON related to catheter policy on 3/1/2013 and 3/4/2013. All staff were in-serviced on 3/1/13 and 3/4/13 related to maintaining resident's dignity. 5) A QA will be conducted, beginning the week of 3/4/13, by the DON / designee on 5 residents a week for 12 weeks, then monthly for 3 months and then quarterly X 3 to ensure drainage bags are covered.
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David Glantz* TITLE: Administrator (X6) DATE: 3-29-13

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

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F 241 Continued From page 1
Registered Nurse (RN) #1 revealed catheter bags should be in privacy bags. She stated that it was a dignity issue. She further stated the resident's catheter bag was usually covered with a privacy bag and that was the first time she had noticed it was not in one.

Interview, on 02/08/13 at 11:30 AM, with State Registered Nursing Assistant (SRNA) #3, who was assigned to Resident #16, revealed catheter bags were supposed to be in privacy or dignity bags, to keep residents from embarrassment but she didn't know where Resident #16's privacy bag was located.

Interview, on 02/08/13 at 11:50 AM, with SRNA #6 revealed catheter bags should be in privacy bags, to protect the dignity of the residents.

Interview, on 02/08/13 at 6:30 PM, with the Unit Manager revealed catheter bags should be in a privacy bag. She stated the privacy bag was for the dignity of the residents.

Interview, on 02/08/13 at 5:40 PM, with the Clinical Manager revealed catheter bags were supposed to be in privacy bags at all times. She stated it was a dignity issue and staff were inserviced frequently.

2. Review of the policy titled "Serving of Food and Drink", dated 11/27/11, revealed dining room residents who were unable to feed themselves "are fed with attention to safety, comfort and dignity".

Observation in the LTC dining room, on 02/05/13 at 11:55 AM, revealed SRNA #22 was standing

F 241 Results will be documented and reviewed by DON / designee and appropriate changes implemented to ensure all resident's dignity is maintained. Results will be reported quarterly to the Quality Assurance committee for review.

6) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance 3/14/13

1.2 SRNA #22/23 was educated by the Unit Manager on the policy importance of sitting next to a resident while feeding on 2/5/2013

1) Central Supply purchased feeding stools for the staff use on 2/11/2013. Feeding stools arrived at the facility and placed in the dining rooms on 2/12/2013.

2) A facility audit was conducted by DON, Unit Manager, and Clinical Coordinator for each meal on 2/11/2013, 2/12/2013 and 2/13/2013 to ensure all staff assisting other residents is seated while feeding and did not have their backs turned toward other residents.

3) All LPNs, RNs, SRNAs were inserviced by DON on 3/1/2013 and 3/4/2013 on Assisting with Meals.

4) A QA will be conducted by the DON / designee, beginning the week of 3/4/13, to observe 2 meals a week for 12 weeks to ensure staff is seated while assisting

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over a resident while feeding him/her. The SRNA was standing with one hand on her hip, while feeding the resident with her other hand. Continued observation revealed SRNA #23 was standing between two (2) residents. She was

feeding one (1) resident with her back to the other resident. The SRNA's bottom was at the level of the face of the resident behind her.

Interview with SRNA #23, on 02/05/13 at 12:25 PM, revealed she usually worked the night shift and was not normally on duty during meal service. She stated she had not been told to sit down while feeding the residents. She further stated she had not thought about her backside turned to the resident behind her, but agreed that was inappropriate.

Interview with SRNA #22, on 02/05/13 at 12:35 PM, revealed she had received training about reading the meal tickets, liquid consistencies and obtaining substitutions, but had not been instructed on how to feed the residents. She stated she had not heard any discussion about sitting while feeding residents.

Interview with the Unit Manager, on 02/08/13 at 2:00 PM, revealed staff should sit down while feeding the residents to promote dignity.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

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residents and their backs are not turned toward other residents. Results will be reported quarterly to the Quality Assurance committee for review.

5) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance

3/14/2013

F281 Services Provided Meet Professional Standards

The services provided or arranged by the facility must meet professional standards of quality.

1. Nursing immediately applied pressure reduction boot for resident #11, Occupational therapy was immediately notified of the need for the palm protector to be adjusted to assure better fit, oral care immediately provided. Resident #11 was offered and given a shower on 2/6/2013 and nursing applied Nair Hair remover to bilateral lower extremities. Resident's #11 air mattress was discontinued per prior documentation, physician was notified and new orders received to discontinue low air loss mattress to bed, continue use of standard pressure reduction mattress.

2. Nursing immediately applied stat-

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to ensure Physician's Orders were followed for three

(3) of twenty-four (24) sampled residents (Resident #11, Resident # 6 and Resident #2). Resident #11 was not wearing a pressure relief boot or palm protector, did not have a pressure relief mattress, oral care was not provided and the staff were not using Nair Hair Remover on the resident's legs as per the Physician's orders. Resident #6 and Resident #2 did not have an anchor for the indwelling catheter as ordered by the Physician.

The findings include:

1. Record review revealed the facility admitted Resident #11 on 02/08/11 with diagnoses which included Hemiplegia, Contractures, Obstructive Hydrocephalus and Traumatic Brain Injury. Further record review revealed the resident was under the age of 40 years old.

Review of the February 2013 Physician's Orders revealed an order to use a pressure reduction boot to the right foot while the resident was in bed, a palm protector at all times as the resident will allow, a low air loss mattress, oral care to be provided after meals and to use Nair Hair Remover on Bilateral Lower Extremities (BtE) two (2) times per week as needed on shower days.

Review of the Minimum Data Set (MDS) Assessment, dated 01/20/13, revealed the resident was assessed by the facility to have a

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- locks to anchor catheter tubing for residents #6 and resident #2.
3. Resident #11 did not show any ill effects from the alleged deficient practice.
 4. Resident #6 and resident #2 did not show any ill effects from the alleged deficient practice.
 5. A facility wide audit was conducted on 2/11/2013, 2/12/2013 and 2/13/2013 by the DON, Unit Manager and Clinical Coordinator to ensure catheter tubing was secure with stat locks and pressure reduction interventions as well as other physician ordered interventions were in place per physician orders and oral care and personal hygiene needs, including shaving, were assessed and provided as per physician orders. No other residents were found to be affected by the alleged deficient practice.
 6. All LPN, RN and SRNAs were in-serviced on 3/1/2013 and 3/4/2013 by the DON related to monitoring and ensuring all interventions are in place per physician orders. New Kardex policy implemented 2/20/13 and all staff in-serviced 3/1/13 and 3/4/13 to ensure all interventions are in place per physician orders. Physician orders checked daily for accuracy and added to Kardex by DON, Unit Manager, Clinical Coordinator and/or Supervisor.

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Continued From page 4

Brief interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) which indicated the resident's cognitive status was moderately impaired. The facility also assessed the resident to require extensive assistance of two (2) with personal hygiene, was at risk for skin breakdown due to pressure and the resident had impaired Range of Motion on Bilateral Upper and Lower Extremities.

Review of the Comprehensive Care Plan revealed a problem of Potential for Impairment of Skin Integrity, initiated 02/08/11, which stated the resident required a low air loss mattress, a pressure reduction boot to right foot while in bed and a palm protector on the left hand at all times. Review of the Comprehensive Care Plan with a problem of Self Care Deficit Related to Brain Trauma, Brain Aneurysm, Contractures of all four (4) extremities and neck and Hemiparesis, initiated 9/01/11, revealed the resident was a total assist of two (2) with Activities of Daily Living (ADLs).

Review of the Nurse Aide Care Plan revealed oral care was to be provided after each meal due to oral residue and pocketing, a low air loss mattress to the bed and a pressure reduction boot to the right foot while in bed.

Observation, on 02/05/13 at 10:15 AM, during initial Tour revealed Resident #11 was sitting in a Gert Chair in his/her room. The surveyor noticed a thick white substance on and between the resident's teeth. The resident stated he/she had to ask the aides to brush his/her teeth, otherwise the aides did not brush them. The resident was wearing shorts, shirt and socks and the hair on

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7. A QA will be conducted by DON or designee, beginning the week of 3/4/13 on 5 residents a week for 12 weeks to ensure interventions are followed per physician orders.
8. The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance

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F282 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.

1. Nursing immediately placed an alarming floor pad next for resident #1 bed.
2. Nursing immediately placed the pressure alarm under resident #13.
3. Nursing immediately applied stat-locks to anchor catheter tubing for resident #2.
4. Nursing immediately removed lap buddy and assessed resident #3 for any s/s of skin breakdown. DON immediately educated SRNA #20, #2, #5, LPN #5, and activity assistant on the restraint policy and checking and releasing devices.
5. Nursing immediately applied

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F 281	<p>Continued From page 5</p> <p>the resident's legs was approximately 1/2 inch long.</p> <p>Observation, on 02/06/13 at 9:05 AM, 9:45 AM, 1:35 PM and 3:45 PM revealed no palm protector was in use.</p> <p>Observation, on 02/06/13 at 11:05 AM, revealed the resident was sitting in a Geri Chair in his/her room wearing pants, shirt and socks and no palm protector was in use. As Resident #11 talked, the surveyor noted the resident's teeth were still coated with build up on and between his/her teeth. The resident stated he/she would like to have his/her legs shaved; however, didn't have the aides shave his/her legs because it was so cold in the shower room and it took the aides so long to shave them.</p> <p>Observation, on 02/08/13 at 10:55 AM, revealed during a skin assessment, performed by Licensed Practical Nurse (LPN) #10 and witnessed by the Clinical Coordinator and Surveyor, the resident's teeth were coated with a thick, white build up on and between the teeth. At 11:25 AM, the resident stated he/she asked the aide to brush his/her teeth on 02/07/13 and 02/18/13 but the aides stated they were too busy. The resident's legs were unshaved, no palm protector or pressure reduction boot was in use.</p> <p>Observations, on 02/05/13 through 02/08/13, revealed no air loss mattress was in use.</p> <p>Interview, on 02/08/12 at 11:30 AM, with State Registered Nursing Assistant (SRNA) #3 revealed she performed oral care as needed and when residents asked her to do so, such as when she</p>	F 281	<p>pressure reduction boot for resident #11, Occupational therapy was immediately notified of the need for the palm protector to be adjusted to assure better fit, oral care immediately provided. Resident #11 was offered and given a shower on 2/6/2013 and nursing applied Nair Hair remover to bilateral lower extremities. Resident's #11 air mattress was discontinued per prior documentation, physician was notified on 2/6/2013 and new orders received to discontinue low air loss mattress to bed, continue use of standard pressure reduction mattress.</p> <ol style="list-style-type: none"> 6. Resident #1 did not show any ill effects from the alleged deficient practice. 7. Resident #13 did not show any ill effects from the alleged deficient practice. 8. Resident #2 did not show any ill effects from the alleged deficient practice. 9. Resident #3 did not show any ill effects from the alleged deficient practice. 10. Resident #11 did not show any ill effects from the alleged deficient practice. 11. A facility wide audit was conducted on 2/11/2013, 2/12/2013 and 2/13/2013 by the DON, Unit Manager and Clinical Coordinator to ensure alarming floor mats, 		

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got residents up in the morning and when residents asked her to perform oral care. Further interview revealed she was frequently the Resident #11's aide and was his/her aide on that particular day, 02/08/13. She stated she did not

get the resident up and the resident did not ask her to brush his/her teeth on 02/08/13. Still further interview revealed she did not shave Resident #11's legs, the shower aide was responsible for that. She further stated the resident had the pressure reduction boot on, earlier in the morning on 02/08/13, when he/she was in the Geri chair and she didn't know who took the boot off. Further interview revealed the resident didn't use the palm protector, it had been discontinued. She also stated she did not know why the low air loss mattress wasn't on the bed.

Interview, on 02/08/13 at 3:51 PM, with Licensed Practical Nurse (LPN) #10 revealed she noticed the Resident #11's teeth had a lot of tartar on them and it takes more than a day or two for that to build up. She further stated she heard the resident tell the surveyor that he/she asked the aide to brush his/her teeth 02/07/13 and 02/08/13 but the aide said she was too busy. Further interview revealed the resident was to have oral care after each meal. She also stated the aides were responsible for brushing residents' teeth and the nurses were responsible for ensuring residents' teeth were brushed. She further stated she did not know why Resident #11's legs were not shaved, according to the Physician's order Nair was to be used on his/her shower days. Continued interview revealed she didn't know why the pressure reduction boot wasn't on Resident #11, she had put the boot on the resident herself. She also stated the resident wore the boot while

F 281 pressure alarms and stat locks were in place per Kardex, as well as other physician order devices to ensure that other residents were not affected by the alleged deficient practice. Resident care was observed house wide to include, but not limited to oral and personal hygiene needs, including shaving, were assessed and provided as per Kardex. No other residents were found to be affected by the alleged deficient practice.

12. New Kardex policy initiated 2/20/13 by the DON to ensure interventions are in place and being followed per plan of care.
13. All LPNs, RNs, SRNAs, and Activity staff members as well as all other staff were in-serviced by the DON, Unit Manager and Clinical Coordinator on 3/1/2013 and 3/4/2013 on the new Kardex policy and following the plan of care (Kardex).
14. A QA will be conducted by the DON or designee starting the week of 3/4/13 on 5 residents a week for 12 weeks to ensure all devices, care observation and care interventions will be properly assessed, placed on the care plan Kardex. Devices will be in place as ordered and / or care completed as assessed. This will be monitored by the audits and evaluated for effectiveness during the weekly meetings with the

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F 281	Continued From page 7 In the Geri chair, she didn't realize the Physician Order was for the resident to wear the boot white in bed. She stated the resident had an order for a palm protector and should have had one on, unless it had been discontinued. Further interview revealed Resident #6 had an order for a Statlock on his/her thigh, she didn't notice that the resident did not have one during the skin assessment and the resident should have had one on his/her thigh. Interview, on 02/08/13 at 4:10 PM, with SRNA #21 Restorative Aide revealed Resident #11's Restorative program was discontinued approximately two (2) weeks earlier. Interview, on 02/08/12 at 6:30 PM, with the Unit Manager revealed Resident #11 had an order to use Nair in the shower, oral care to be provided after each meal and a palm protector was to be used and the Physician Orders should have been followed. Further interview revealed a Physician Order was required to discontinue the palm protector and Restorative program. Continued interview revealed Resident #6 had an order for a Statlock and should have had one on his/her thigh. She stated the charge nurse was responsible for ensuring Physician Orders were followed and the Unit Manager was responsible for ensuring the Charge Nurses were doing their job. Interview, on 02/08/13 at 4:14 PM, with the Clinical Coordinator (Interim Unit Manager) revealed she noticed the Resident #11's teeth needed oral care performed, oral care should have been performed after each meal. Further interview revealed the resident had an order for	F 281	Administrator, QA meetings, and through scheduled MDS assessments. 15. The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies. Alleged Date of Compliance	3/14/2013

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Nair to be used. Further interview revealed the resident had the boot on when he/she was in the Geri chair, earlier that morning, however she wasn't sure if the boot was ordered to be used at all times. Further interview revealed she noticed

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the resident did not have the palm protector on the morning of 02/08/13 when she was doing rounds. She questioned the restorative aide who stated she hadn't seen the palm protector so she (Clinical Coordinator) wrote an order to put the palm protector on hold until the resident could be evaluated. Further interview revealed there should have been an order to discontinue Restorative, however she wasn't aware Restorative was no longer seeing the resident.

Interview, on 02/08/13 at 5:40 PM, with the Clinical Coordinator (Interim Unit Manager) revealed the resident did have an order for Nair. She further stated the resident's bed did not have a low air loss mattress on it. She stated no order had been written to discontinue the low air loss mattress. She further stated she guessed they needed the mattress somewhere else but failed to write the discontinue order. Continued interview revealed Resident #2 had a Physician Order for a Statlock and should have had one on. Further interview revealed the Unit Manager was responsible for ensuring Physician Orders were followed.

Interview, on 02/08/13 at 7:50 PM, with the Clinical Coordinator (Interim Unit Manager) revealed, according to the Plan of Care Resident Response Rate Report, the SRNAs were charting Resident #11 was independent with personal hygiene. She further stated the resident was totally dependent personal hygiene, not

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2013
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9 independent. 2. Record review revealed the facility admitted Resident #6 with diagnoses of Urinary Tract Infection, Urinary Retention, Neurogenic Bladder and Cerebrovascular Disease. Review of the February 2013 Physician Orders revealed an order for a Statlock for Uninary catheter to upper thigh, to change when needed. Review of the Minimum Data Set (MDS) Resident Assessment and Care Screening (dated 01/04/13) revealed the facility assessed Resident #6 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident had no cognitive impairment. The MDS also revealed the resident had an indwelling catheter (Foley). Review of the Comprehensive Care Plan revealed the resident was to have a Foley strap to leg at all times. Review of the Nurse Aide Care Plan revealed the resident was to have a Statlock to thigh. 3. Review of the clinical record revealed Resident #2 was admitted by the facility on 11/10/11 with diagnoses which included Urinary Retention. Review of the current Physician's Orders for February 2013 revealed an order, dated 09/17/12, to secure the catheter to the resident's leg with a Stat Lock device, to be changed weekly. (Securing the catheter to the leg prevents pulling and trauma at the urethra when the catheter bag	F 281		

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F 281	Continued From page 10 is moved or the resident is turned and repositioned.) Observation of Resident #2, on 02/06/13 at 10:45 AM, revealed the catheter was not secured to the resident's leg. Subsequent observation, on 02/08/13 at 10:00 AM, revealed the catheter was not secured to the resident's leg. Interview with Licensed Practical Nurse (LPN) #13, on 02/08/13 at 10:10 AM, revealed she did not know why the Stat Lock device was not in use for securing the catheter to Resident #2's leg. She stated the resident "picks at stuff" and perhaps that was why the strap was left off the resident. Interview with the Unit Manager, on 02/08/13 at 2:00 PM, revealed Resident #2 should have had a leg strap in place, according to the Physician's Order and the care plan. She stated all residents with catheters should have a Stat Lock device in place.	F 281	
F 282 SS=E	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 policies it was determined	F 282	

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F 282 Continued From page 11
the facility failed to ensure services were provided by the facility in accordance with the residents' written plan of care for five (5) of twenty-four (24) sampled residents (Residents #1, #2, #3, #11, and #13).

F 282

Resident #1 was observed in bed without an alarming floor mat next to the bed as care planned under "Potential for Injuries/falls" on the resident's comprehensive plan of care. Resident #13 was observed seated in a dining room chair without a chair pressure alarm as care planned under "Potential for injuries/falls". Resident #2 was observed not to have a leg strap in place to secure his/her catheter tubing as noted on their plan of care. Resident #3's lap buddy was not released during meals and activities as indicated on the plan of care. Resident #11 was observed to have a thick white substance on and between their teeth, his/her legs were not shaved and did not have a pressure reduction boot, palm protector or a low air loss mattress in use as per the care plan.

The findings include:

Review of the facility policy titled, "Care Plans-Comprehensive", no date, revealed each Resident would have a comprehensive care plan developed to meet the medical, physical, nutritional, nursing, mental and psychological needs of the Resident. Review of the section "Policy Interpretation and Implementation" under #1 revealed based on assessment and reassessment the comprehensive care plan would identify, integrate, and prioritize the resident's care needs.

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F 282	Continued From page 12 Review of the facility's policy: "Fall Prevention", undated, revealed the facility was committed to evaluate all residents for fall risks and attempt to assess and implement measures to reduce and hopefully eliminate falls which caused injury. Under "Protocol" all residents will be assessed for indicators which indicate the resident may be a fall risk. Factors which were considered to put a resident in a higher risk category included a history of falls, along with various diagnosis, and Dementia. Under "Procedure" any preventative measures identified needed to be added to the resident's plan of care and implemented. The preventive measures were to be checked for placement by both aides and nurses. 1. Review of Resident #1's medical record revealed the resident was admitted by the facility on 06/12/12 with diagnoses which included Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety, Depression, and History of Falls. Review of the Admission Minimum Data Set, 06/19/12, and the Quarterly Minimum Data Set (MDS) Assessment, revealed the resident was assessed as having severely impaired cognitive skills for daily decision making. Continued review of Resident #1's MDS revealed under functional status the resident was assessed to need extensive assistance of two (2) with transfers and total assistance with ambulation. In addition, the resident was assessed as having a history of falls prior to admission and since admission. Review of Resident #1's Care Area Assessment (CAA) revealed the resident triggered and was care planned for Falls, 06/20/12, due to balance problems, a history of falls, a right hip fracture, received anti-anxiety and antidepressant	F 282			

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F 282 Continued From page 13
medications, cognitive impairment, Alzheimer's disease, and other dementia.

F 282

Review of Resident #1's Comprehensive Care Plan revealed the care plan: Potential for injures/falls, initiated 08/12/12, and the related interventions included an alarming floor mat next to bed.

Review of Resident #1's Treatment Administration Record (TARS), for January and February 2013, revealed it included the following fall interventions to assess: bed against wall, bed bolsters, high back reclining wheelchair with wedge cushion, pressure alarm while in bed, and pressure alarm while in chair. Further review of the TARS revealed no alarming floor mat listed to assess placement.

Observations, on 02/06/13 at 3:45 PM and on 02/07/13 at 9:55 AM, revealed Resident #1 was in bed and no alarming floor mat was observed next to the bed as care planned.

Interview, on 02/08/13 at 10:15 AM, with State Registered Nursing Assistant (SRNA) #20, who cared for Resident #1 on 02/07/13 and 02/08/13, revealed the floor mat was not on the floor yesterday (02/07/13, but had been placed next to the bed this morning (02/08/13) by management. The SRNA stated she thought the resident had the mat on the floor about a month ago, but did not remember it being on the floor until today.

Interview, on 02/08/13 at 10:20 AM, with Licensed Practical Nurse (LPN) #2 revealed Resident #1 was a fall risk. The LPN stated she had removed the fall mat alarm because the fall

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F 282 Continued From page 14
prevention intervention was not listed on the TAR. She further stated the order for the fall mat alarm was not been transcribed on the TAR to sign off mat placement was checked and monitored.

F 282

Continued interview with LPN #2 revealed she had removed the mat from the floor because it was not listed on the TAR and had not checked the orders or the Comprehensive Care Plan for the fall mat.

Interview, on 02/08/13 at 3:15 PM, with the Director of Nursing (DON) revealed Resident #1 was care planned for an alarming floor mat and also had an order. The DON stated the resident was supposed to have a pressure alarm mat on the side of his bed. She further stated orders were supposed to transition to the TAR, but the floor mat order was not listed. Continued interview with the DON the floor mat alarm had been removed by LPN #2 because it was not listed on the TAR, but the nurse should have checked the orders prior to removal.

2. Review of Resident #13's medical record revealed the resident was admitted by the facility on 11/02/10 with diagnoses which included Alzheimer's Disease, Depression, Non-Alzheimer's Dementia, Debility, Osteoarthritis, Muscle Weakness, and Abnormality of Gait. Review of the most recent Comprehensive MDS dated 07/29/12 and Quarterly MDS dated 01/14/13, revealed the resident was assessed as being cognitively impaired. Further review of the MDS data revealed the resident was assessed as needing extensive assist of two (2) persons with transfers and limited assistance of one (1) with ambulation. In addition, the resident was assessed to have

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F 282	Continued From page 15 had a history of falls at the facility since admission.	F 282		
	Review of Resident #13's CAA revealed the resident triggered for falls due to balance problems, history of falls, antidepressant medication, cognitive impairment, diagnoses which included: Congestive Heart Failure, Arthritis, Alzheimer's disease, Other Dementia, and cognitive impairment.			
	Review of Resident #13's Comprehensive Care Plan revealed the resident was care planned for: Potential for injuries/falls, date initiated 04/20/12, and it included an intervention for pressure alarms to the bed and chair to alert staff resident may be attempting to transfer without assistance and to remind the resident of the need for assistance.			
	Observation of breakfast meal service, on 02/06/13 at 8:45 AM to 9:00 AM, revealed Resident #13 was seated in a regular chair at the table with no pressure alarm device on the chair. The pressure alarm device was observed in the resident's wheelchair next to the resident.			
	Interview, on 02/06/13 at 9:00 AM, with SRNA #16 revealed the resident insisted on sitting in regular chairs at times and would get himself/herself into the chairs. The aide stated the resident was supposed to have a pressure alarm on the chair per the care plan and should have had the alarm in place for safety reasons.			
	Interview, on 02/06/13 at 9:20 AM, with SRNA #1 revealed Resident #13 had a history of falls. She stated the resident was care planned for a			

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F 282	<p>Continued From page 16</p> <p>pressure alarm to both the bed and chair because the resident would attempt to get up by himself/herself. Further interview with the aide revealed the resident liked to sit in regular chairs, at times, and staff was supposed to make sure the pressure alarm was placed on the chair for safety.</p> <p>Interview, on 02/08/13 at 10:12 AM, with LPN #4 revealed Resident #13 was care planned for pressure alarms to the bed and chair because of safety purposes to let them know if the resident tried to get up. She stated staff was supposed to make sure if the resident was not in his/her wheelchair they placed the alarm where the resident sat. After being told the resident was observed in a chair without a pressure alarm, the LPN stated the person who had transferred the resident to the chair should have put the alarm underneath him, if it was not it was a safety concern.</p> <p>Interview, on 02/08/13 at 3:00 PM, with the DON revealed Resident #13 was care planned for pressure alarms and all staff was responsible to monitor pressure alarm placement for safety purposes. She stated the resident was a fall risk due to dementia and poor balance and it was important to have the safety device in place. She further stated the resident was impulsive, got agitated at times, was difficult to re-direct, and liked to sit in regular chairs at times. Continued interview with the DON revealed sometimes the resident would not allow staff to place the alarm underneath her/him; however, staff should have gone back and attempted to put the alarm underneath the resident.</p>	F 282		
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F 282 | Continued From page 17

F 282

3. Record review of Resident #3's MDS, dated 01/25/13, revealed he/she was assessed as severely cognitively impaired. Further review of the MDS revealed Resident #3 was an assist of two (2) staff members for bed mobility, transfer, and toilet use. In addition, Resident #3 was an assist of one (1) staff member for locomotion on unit, dressing, eating, personal hygiene, and bathing. Lastly, the MDS indicated Resident #3 used a wheelchair for locomotion.

Review of Resident #3's comprehensive care plan titled, "Restraint device", initiated 06/19/12, revealed Resident #3 had a lap buddy in place while in his/her wheelchair for safety and to remind him/her to ask for assistance prior to transfer. Interventions on the care plan included checking the lap buddy for placement every thirty (30) minutes and releasing the lap buddy every two (2) hours, during meals, for toileting, and during activities with staff attendance.

Review of Resident #3's Nurse Aide Care Plan otherwise referred to as a "Cardex", dated 02/08/13, revealed Resident #3 was to have a lap buddy in place while in his/her wheelchair. Also, the Cardex stated Resident #3's lap buddy was to be checked every thirty (30) minutes and released every two (2) hours including during meals, toileting and activities.

Review of the last Physical Restraint Assessment/Review form, dated 11/16/12, revealed Resident #3's lap buddy was to be removed during meals and activities. The assessment also stated Resident #3's lap buddy was to be released every two (2) hours.

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F 282 Continued From page 18

F 282

Observation, on 02/05/13 at 6:00 PM, during supper meal revealed Resident #3 was in his/her wheelchair with the lap buddy in place. The lap buddy remained in place throughout the meal, while Resident #3 was being assisted by staff. An additional observation, on 02/06/13 at 8:45 AM, revealed Resident #3 had his/her lap buddy in place throughout the breakfast meal. Another observation, on 02/06/13 at 12:50 PM, revealed Resident #3 continued to wear the lap buddy placed on her wheelchair while being assisted with lunch.

Observation, on 02/06/13 at 10:15 AM, revealed Resident #3 had his/her lap buddy in place while attending activities with staff members present. Again, on 02/07/13 at 10:15 AM, Resident #3 was observed to have his/her lap buddy in place during activities with staff members present.

Observation, on 02/07/13 at 10:25 AM, revealed Resident #3 could not remove the lap buddy on command. Licensed Practical Nurse (LPN) # 5 was present and asked Resident #3 to remove his/her lap buddy three times. Resident #3 made no attempts to remove the lap buddy.

Interview with State Registered Nursing Assistant (SRNA) #20, who was caring for Resident #3, on 02/07/13 at 10:00 AM, revealed the lap buddy was to be checked every thirty (30) minutes for correct placement. However, SRNA #20 did not know how often the lap buddy was to be released. SRNA #20 stated she thought Resident #3's lap buddy was to be in place while eating and during activities.

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F 282	Continued From page 19 Interview with SRNA #2, on 02/07/13 at 10:05 AM, revealed she occasionally provided care for Resident #3. SRNA #2 stated she did not think Resident #3's lap buddy was to be released during meals or activities. SRNA #2 stated she was not sure how often the lap buddy was to be released, but she thought it was supposed to be released every hour for twenty (20) minutes. Interview with SRNA #5, on 02/06/13 at 2:10 PM, revealed she had assisted Resident #3 with lunch that day. SRNA #5 stated Resident #3's lap buddy was not released during meals or activities. She stated the lap buddy was released every two hours during incontinence care. Interview with the Activity Assistant, on 02/07/13 at 2:45 PM, stated she was unaware Resident #3's lap buddy was to be released during meals or activities. Interview with LPN #6 who was caring for Resident #3, on 02/06/13 at 2:37 PM, revealed Resident #3's lap buddy was to be released every two (2) hours. LPN #6 also stated Resident #3's lap buddy was to be released during meals and activities. Interview with LPN #5 who was caring for Resident #3, on 02/07/13 at 10:18 AM, revealed Resident #3's lap buddy was to be released every two (2) hours. Although, LPN #5 stated she did not believe Resident #3's lap buddy was not to be released during meals or activities. Interview with MDS Coordinator, on 02/08/13 at 10:17 AM, revealed SRNAs are aware of the needs of the Residents based on the Cardex.	F 282		
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F 282	<p>Continued From page 20</p> <p>The MDS Coordinator reported the Cardex was generated from the comprehensive plan of care and serves as a guide to the SRNAs providing care. The MDS Coordinator reported these forms are kept at the nurse's station on each wing, and are updated as needed. Additionally, the MDS Coordinator stated the current plan of care for Resident #3 should be followed. Lastly, The MDS Coordinator stated the nurses are responsible for ensuring the plan of care was followed for each Resident.</p> <p>Interview with the Director of Nursing (DON), on 02/10/13 at 4:05 PM, revealed current plans of care for each Resident should be followed. She stated staff are aware of the care plan needs through the use of the Cardex which is accessible to all SRNAs. Furthermore, she stated the nursing staff are responsible for ensuring the plan of care is followed.</p> <p>4. Review of the clinical record revealed the facility admitted Resident #2 on 11/10/11 with diagnoses which included Urinary Retention. Continued review revealed the resident had an indwelling urinary catheter to drain the bladder.</p> <p>Review of the current active Physician's Orders revealed an order, initiated 09/17/12, for a Stat Lock device to secure the resident's catheter to the leg. (Securing the catheter to the leg in this way prevents pulling and trauma to the urethra when the catheter drainage bag is moved or during turning and repositioning of the resident.)</p> <p>Review of the comprehensive Care Plan, dated 08/13/12, revealed the intervention "Foley strap to leg at all times".</p>	F 282		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 21 Observation of Resident #2, on 02/06/13 at 10:45 AM, revealed the catheter was not secured to the resident's leg. Subsequent observation, on 02/08/13 at 10:00 AM, revealed the catheter was not secured to the resident's leg.	F 282			
	<p>Interview with LPN #13, on 02/08/13 at 10:10 AM, revealed she did not know why the Stat Lock device was not in use for securing the catheter to Resident #2's leg. She stated the resident "picks at stuff" and perhaps that was why the strap was left off the resident.</p> <p>Interview with the Unit Manager, on 02/08/13 at 2:00 PM, revealed Resident #2 should have had a leg strap in place, according to the Physician's order and the care plan. She stated all residents with catheters should have a Stat Lock device in place.</p> <p>5. Record review revealed the facility admitted Resident #11 on 02/08/11 with diagnoses which included Hemiplegia, Contractures of Forearm, Shoulder, Hand and Lower Leg, Obstructive Hydrocephalus and Traumatic Brain Injury.</p> <p>Review of the February 2013 Physician Orders revealed orders to use a pressure reduction boot to the right foot while the resident was in bed, a palm protector to be used at all times as the resident will allow, a low air loss mattress, oral care to be provided after meals and to use Nair Hair Remover on Bilateral Lower Extremities (BLE) two (2) times per week as needed on shower days- Wednesday and Saturday, apply prior to shower and wash off thoroughly in the shower, also monitor skin of Bt.E for reaction to Nair on shower days.</p>				

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F 282	<p>Continued From page 22</p> <p>Review of the Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 01/20/13, the resident was assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated the resident's cognitive status was moderately impaired. The facility also assessed Resident #11 to require extensive assistance of two (2) with personal hygiene, was at risk for skin breakdown due to pressure and had impaired Range of Motion on Bilateral Upper and Lower Extremities.</p> <p>Review of the Comprehensive Care Plan Potential for Impairment of Skin Integrity, initiated 02/08/11, revealed the resident required a low air loss mattress, a pressure reduction boot to right foot while in bed, a palm protector on the left hand at all times. Review of the Comprehensive Care Plan for Self Care Deficit Related to Brain Trauma, Brain Aneurysm, Contractures to all four (4) extremities and his/her neck and Hemiparesis, initiated 9/01/11, revealed the resident was a total assist of two (2) with Activities of Daily Living (ADLs) and was to have a shower two (2) days each week.</p> <p>Review of the Nurse Aide Care Plan revealed oral care was to be provided after each meal due to oral residue and pocketing, was to have a low air loss mattress to the bed and a pressure reduction boot to the right foot while in bed.</p> <p>Observation, on 02/05/13 at 10:15 AM, during Initial Tour revealed Resident #11 was sitting in a Geri Chair in his/her room. The resident stated he/she had to ask the aides to brush his/her teeth, otherwise the aides did not brush them.</p>	F 282		
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F 282 Continued From page 23
The resident was wearing shorts, shirt and socks and the hair on the resident's legs was approximately 1/2 inch long.

F 282

Observation, on 02/06/13 at 9:05 AM, 9:45 AM, 1:35 PM and 3:45 PM revealed no palm protector was in use.

Observation, on 02/06/13 at 11:05 AM, revealed the resident was sitting in a Geri Chair in his/her room wearing pants, shirt and socks and no palm protector was in use. As Resident #11 talked, the surveyor saw the resident's teeth were coated with build up on and between his/her teeth. The resident stated he/she would like to have his/her legs shaved, however, didn't have the aides shave his/her legs because it was so cold in the shower room and it took the aides so long to shave them.

Observation, on 02/08/13 at 10:55 AM, revealed, during a skin assessment, performed by Licensed Practical Nurse (LPN) #10 and witnessed by the Clinical Coordinator and Surveyor, Resident #11's teeth were coated with a thick, white build up on and between the teeth. At 11:25 AM, the resident stated he/she asked the aide to brush his/her teeth on 02/07/13 and 02/08/13 but the aide stated they were too busy. The resident's legs were unshaved, no palm protector was in use and no pressure reduction boot was in use.

Observations, on 02/06/13 through 02/08/13, revealed no air loss mattress was in use.

Interview, on 02/08/12 at 11:30 AM, with SRNA #3 revealed she performed oral care as needed and when the residents asked her to do so, such as

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F 282 Continued From page 24
when she got the residents up in the morning and when the residents asked her to perform oral care. Further interview revealed she was frequently Resident #11's aide and was his/her aide on 02/08/13. She stated she did not get the resident up and the resident did not ask her to brush his/her teeth on 02/08/13. Still further interview revealed she did not shave Resident #11's legs, the shower aide would do that. She further stated the resident had the pressure reduction boot on when he/she was in the Geri chair earlier that morning, on 02/08/13, and she doesn't know who took it off. Further interview revealed Resident #11's palm protector had been discontinued. She also stated she did not know why the low air loss mattress wasn't on Resident #11's bed.

F 282

Interview, on 02/08/13 at 3:51 PM, with LPN #10 revealed she noticed Resident #11's teeth had a lot of tartar on them and it takes more than a day or two for that to build up. She further stated she heard the resident tell the surveyor that he/she asked the aide to brush his/her teeth 02/07/13 and 02/08/13 but the aide said she was too busy. Further interview revealed Resident #11 was to have oral care after each meal. She also stated the aides were responsible for brushing residents' teeth and the nurses were responsible for ensuring residents' teeth were brushed. She further stated she did not know why Resident #11's legs were not shaved, according to the Physician's order Nair was to be used on his/her shower days. Continued interview revealed she didn't know why the pressure reduction boot wasn't on Resident #11, she had put it on the resident herself. She also stated Resident #11 wore the pressure reduction boot while in the Geri

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F 282 Continued From page 25
 chair and she didn't realize the Physician Order was for the resident to wear the boot while in bed. She stated the resident also had an order for a palm protector to be used and should have had one on, unless it had been discontinued. Further interview revealed Resident #6 had an order for a Statlock on his/her thigh, she didn't notice that the resident did not have one on his/her thigh during the skin assessment and there should have been one on the resident.

Interview, on 02/08/13 at 4:10 PM, with SRNA #21 Restorative Aide revealed Resident #11's Restorative program was discontinued approximately two (2) weeks earlier.

Interview, on 02/08/12 at 6:30 PM, with the Unit Manager revealed Resident #11 had Physician Orders to use Nair in the shower, oral care to be provided after each meal and a palm protector to the resident's left hand and the orders should have been followed. Further interview revealed a Physician Order was required to discontinue the palm protectors and Restorative program. Continued interview revealed Resident #6 had an order for a Statlock and one should have been on his/her thigh.

Interview, on 02/08/13 at 4:14 PM, with the Clinical Coordinator (Interim Unit Manager) revealed she noticed Resident #11's teeth needed oral care performed, oral care was supposed to be provided after each meal. Further interview revealed the resident had an order for Nair to be used. Further interview revealed the resident had the pressure reduction boot on when he/she was in the Geri chair earlier that morning, on 02/08/13, however she wasn't

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F 282	Continued From page 26 sure if the boot was ordered to be used at all times. Further interview revealed she noticed the resident did not have the palm protector on the morning of 02/08/13 when she was doing rounds, she spoke with the restorative aide who stated she hadn't seen the palm protector so she, the Clinical Coordinator, wrote an order (on 02/08/13) to put the palm protector on hold until the resident could be evaluated (by Therapy or Restorative).	F 282		
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	<p>Interview, on 02/08/13 at 5:40 PM, with the Clinical Coordinator (Interim Unit Manager) revealed Resident #11 did have an order for Nair. She further stated the resident's bed did not have a low air loss mattress on it. She stated no order had been written to discontinue the low air loss mattress. She further stated she guessed they needed the mattress somewhere else but failed to write the discontinue order.</p> <p>Interview, on 02/08/13 at 7:50 PM, with the Clinical Coordinator (Interim Unit Manager) revealed, according to the Plan of Care Resident Response Rate Report, the SRNAs were charting Resident #11 was independent with personal hygiene. She further stated the resident was totally dependent personal hygiene, not independent.</p>		<p>F312 ADL Care Provided for Dependent Residents</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.</p> <ol style="list-style-type: none"> Nursing immediately provided oral care for Resident #11. Resident #11 was offered and given a shower on 2/6/2013 and nursing applied Nair Hair remover to bilateral lower extremities. DON immediately in-serviced SRNA #3, LPN #10 and Clinical Coordinator on 2/5/2013 regarding properly assessing residents' needs and providing or assisting with care needs as indicated in the residents' plan of care. A facility wide audit was conducted on 2/11/2013, 2/12/2013., and 2/14/2013 by the DON, Unit 	
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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		
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F 312 Continued From page 27
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to provide necessary services to maintain good nutrition, grooming, personal hygiene and oral hygiene for one (1) of twenty-four (24) sampled residents (Resident #11) as evidenced by a thick, white coating on and between Resident #11's teeth. In addition, the staff was not using Nair Hair Remover on the resident's legs.

The findings include:

Record review revealed the facility admitted Resident #11 on 02/08/11 with diagnoses which included Hemiplegia, Contractures of Forearm, Shoulder, Hand and Lower Leg, Obstructive Hydrocephalus and Traumatic Brain Injury. Further record review revealed the resident was under the age of 40 years old.

Review of the February 2013 Physician's Orders revealed an order to provide oral care after each meal, due to oral residue and pocketing and an order to use Nair Hair Remover on Bilateral Lower Extremities (BLE) two (2) times per week as needed on shower days- Wednesday and Saturday; apply prior to shower and wash off thoroughly in the shower, also monitor skin of BLE for reaction to Nair on shower days.

Review of the Minimum Data Set (MDS) Assessment and Care Screening revealed the resident was assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) which indicated the resident's cognitive status was moderately

F 312

Manager and Clinical Coordinator to ensure all residents were receiving appropriate assistance with ADLs. No other residents were found to be affected by the alleged deficient practice.

- Interview with resident #11 revealed that resident #11 did not show any ill affects from the alleged deficient practice. No other residents showed any ill affects from the alleged deficient practice.
- All LPNs, RNs and SRNAs were in-serviced on 3/1/13 and 3/4/2013 related to assessing, providing and assisting residents as indicated with ADLs.
- A QA will be conducted by the DON or designee, beginning the week of 3/4/13 on 5 residents a week for 12 weeks and then quarterly to ensure all residents are receiving appropriate assistance with ADLs. Results will be monitored by DON or designee and appropriate changes implemented to ensure residents are receiving appropriate assistance with ADLs. Results will be reported quarterly to the Quality Assurance committee for review.
- The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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F 312 Continued From page 28
impaired. The facility also assessed the resident to require extensive assistance of two (2) with personal hygiene.

F 312
Alleged Date of Compliance

3/14/2013

Review of Resident 11's Comprehensive Care Plan for Potential for Altered Dental Status, Requires Assist with Dental Hygiene, initiated 02/08/11, revealed State Registered Nursing Assistants (SRNA) were to provide oral care after each meal due to oral residue and pocketing. Review of the Comprehensive Care Plan Self Care Deficit Related to Brain Trauma, Brain Aneurysm, Contractures of all four (4) extremities and his/her neck, Hemiparesis, initiated 9/01/11, revealed the resident was a total assist of two (2) with Activities of Daily Living (ADLs).

Review of the Nurse Aide Care Plan revealed oral care was to be provided after each meal due to oral residue and pocketing.

Observation, on 02/05/13 at 10:15 AM, during Initial Tour revealed Resident #11 was sitting in a Geri Chair in his/her room. The surveyor noted the resident's teeth were coated with a thick white substance. The resident stated he/she had to ask the aides to brush his/her teeth, otherwise the aides did not brush them. The resident was wearing shorts, shirt and socks and the hair on the resident's legs was approximately 1/2 inch long.

Observation, on 02/06/13 at 11:05 AM, revealed the resident was sitting in a Geri Chair in his/her room wearing pants, shirt and socks. As Resident #11 talked the surveyor noticed the resident's teeth were still coated with build up on and between his/her teeth. The resident stated

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F 312 | Continued From page 29
he/she would like to have his/her legs shaved, however, didn't have the aides shave his/her legs because it was so cold in the shower room and it took the aides so long to shave them.

F 312

Observation, on 02/08/13 at 10:55 AM, revealed, during a skin assessment, performed by Licensed Practical Nurse (LPN) #10 and witnessed by the Clinical Coordinator and Surveyor, Resident 11's teeth were coated with a thick, white build up on and between the resident's teeth. At 11:25 AM, the resident stated he/she asked the aide to brush his/her teeth on 02/07/13 and 02/18/13 but the aide stated they were too busy.

Interview, on 02/08/13 at 11:30 AM, with SRNA #3 revealed she performed oral care as needed and when residents asked her to do so, such as when she got residents up in the morning and when residents asked her to perform oral care. Further interview revealed she was frequently the resident's aide and was his/her aide on that particular day, 02/08/13. She stated she did not get the resident up and the resident did not ask her to brush his/her teeth. Still further interview revealed she did not shave Resident #11's legs, the shower aide was supposed to do that.

Interview, on 02/08/13 at 3:51 PM, with Licensed Practical Nurse (LPN) #10 revealed she noticed Resident #11's teeth had a lot of tarter on them and it takes more than a day or two for that to build up. She further stated she heard the resident tell the surveyor that he/she asked the aide to brush his/her teeth 02/07/13 and 02/08/13 but the aide said she was too busy. Further interview revealed the resident was to have oral care after each meal. She also stated the aides

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F 312 Continued From page 30
were responsible for brushing residents' teeth and the nurses were responsible for ensuring residents' teeth were brushed. She further stated she did not know why Resident #11's legs were not shaved, according to the Physician's order Nair was to be used on his/her shower days.

Interview, on 02/08/12 at 6:30 PM, with the Unit Manager revealed Resident #11 had an order to use Nair in the shower and oral care was supposed to be performed after each meal. She stated the charge nurse was responsible for ensuring orders were followed.

Interview, on 02/08/13 at 4:14 PM, with the Clinical Coordinator (Interim Unit Manager) revealed she noticed the resident's teeth needed oral care performed, oral care should have been performed after each meal.

Interview, on 02/08/13 at 5:40 PM, with the Clinical Coordinator (Interim Unit Manager) revealed the resident did have an order for Nair to be used and the Unit Manager was responsible for ensuring orders were followed.

Interview, on 02/08/13 at 7:50 PM, with the Clinical Coordinator (Interim Unit Manager) revealed, according to the Plan of Care Resident Response Rate Report, the SRNAs were charting Resident #11 was independent with personal hygiene. She further stated the resident was totally dependent personal hygiene, not independent.

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

The facility must ensure that the resident

F 312

F323 Free of Accident Hazards/Supervision/Devices

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

1. Environmental Service Director designee immediately fixed the observed screw sticking out of the wall vent on 2/6/2013.
2. Environmental director adjusted the water temperatures on 2/6/2013 and re-checked rooms 201, 225, 114 during the evening of 2/6/2013 and morning of 2/7/2013 with noted water temperature between 100 and 110.
3. Medication cup found in room 102 A was immediately discarded.
4. No residents showed ill affects for the alleged deficient practice.
5. A facility wide audit was conducted by the DON, Unit Manager and Clinical Coordinator on 2/11/2013, 2/12/2013 and 2/13/2013 to ensure personal care items were stored properly unless resident was assessed as being able and safe to keep at bedside.
6. A facility wide tour was conducted by Environmental Service Director

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F 323 Continued From page 31
environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 323 and Maintenance Assistance on 2/11/2013 to ensure all vents were properly secured and posed no hazards to residents or staff as well as ensured no other potential safety hazards were present.

This REQUIREMENT is not met as evidenced by:
Based on observation and Interview it was determined the facility failed to ensure the resident environment remained free of accident hazards. During a tour with the Environmental Services Director (ESD) on 02/06/13 at 2:15 PM, a screw was observed sticking approximately one inch out of a wall vent in the 200/300 unit dining room. Further observation on the environmental tour, revealed water temperatures in rooms on both the 200 and 300 units were in excess of 110 degrees Fahrenheit (F). In addition, observation on tour, on 02/05/13 at 10:15 AM, revealed a medicine cup with a white paste like substance on the bedside table in room 102 bed A of the Memory Care Unit.

The findings include:

1. During tour with the ESD, on 02/06/13 at 2:15 PM, a screw was observed protruding from a wall vent approximately 1 inch in the 200/300 unit shared dining room. An interview with the ESD at that time revealed he understood the protrusion could lead to potential skin tears to residents, especially ambulatory residents.
2. Water temperatures were taken throughout

7. Environmental Service Director conducted a house wide audit checking water temps to ensure water temperatures are between 100 and 110 degrees Fahrenheit.
8. All RNs, and LPNs were in-serviced on 3/1/2013 and 3/4/2013 by DON, Unit Manager and Clinical Coordinator related to the importance of providing an environment free of accident hazards.
9. All staff was in-serviced on 3/1/2013 and 3/4/2013 by the DON, Unit Manager and Clinical Coordinator on the policy on completing work orders and reporting repair needs as indicated.
10. The Maintenance Director and maintenance assistance was in-serviced on 2/11/2013 by the Administrator on the importance of ensuring water temperatures are between 100-110 degrees at all times and checking to ensure the vents are secure and pose no hazards to residents or staff.
11. A Quality Assurance study will be conducted beginning 3/4/13 by the Director of Environmental services, DON or designee to ensure an

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F 323 Continued From page 32
the facility with the ESD, with temperatures of 112 degrees F observed in room 201 at 2:52 PM, and in room 114 at 3:00 PM. A temperature of 117 degrees F was observed in room 225 at 3:12 PM. Interview with the ESD at that time revealed, although the facility had no policy regarding water temperatures, he worked to follow the regulations of maintaining temperatures in resident rooms between 100 and 110 degrees F. The ESD recognized that temperatures in excess of 110 degrees F could result in burns to residents.

3. Interview, on 02/08/13 at 3:15 PM, with the Director of Nursing (DON) revealed she was unsure they had a policy about the storage of lotions or creams, but it was the expectation was creams and lotions would not be kept at the bedside in the Memory Unit.

Observation during tour of the Memory Unit, on 02/05/13 at 10:15 AM, revealed a medicine cup with a white paste like substance on a bedside table in room 102 by bed A. The aide removed the medicine cup upon observation.

Interview, on 02/05/13 at 10:15 AM, with State Registered Nursing Assistant (SRNA) # 17 revealed she was unsure what was in the medicine cup, but it should have been removed. The SRNA further stated on this unit it was a safety issue because a resident might have attempted to eat it.

Interview, on 02/05/13 at 10:35 AM, with Licensed Practical Nurse (LPN) # 5 revealed they should not leave medications unattended. The LPN stated it could have been some kind of skin treatment and should not have been left on the

F 323 environment free from accident hazards. Five resident rooms and facility corridors will be inspected each week x 12 weeks by DON, Environmental Service Director or designee to ensure an environment free from accident hazards and safety interventions are in place, such as fall interventions in place / effective, and skin interventions in place. Any concerns noted will be relayed to the Environmental Services Director, DON or designee for repairs or given to DON or designee to evaluate the interventions and its effectiveness. Results will be evaluated by the Environmental Services Director / DON / designee to ensure compliance and reported quarterly to the Quality Assurance committee for review.

12. QA audit will be conducted by the Environment Service Director, beginning the week of 3/4/13 on 5 resident rooms a week x 12 weeks at different intervals during the day to ensure water temperatures are between 100 and 110 degrees Fahrenheit. The results will be evaluated by the Environmental Services Director to ensure compliance and reported quarterly to the Quality Assurance committee for review.

13. The Administrator will ensure compliance through review and

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F 323	Continued From page 33 resident's beside table. Further interview with the LPN revealed they have wandering residents on the unit and it was a safety issue to have left the medicine cup unattended.	F 323	evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.	
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F 371 SS=D	<p>Interview, on 02/08/13 at 10:50 AM, with LPN # 2 revealed the resident in room 102 bed A got Baza Cream and Thera lotion topical treatments which were both white substances. The LPN further stated if she had put the treatments in a medicine cup they were supposed to throw the cup away once applied. Further interview with the LPN revealed it was a safety problem if it had been left out because a resident might have gotten into it.</p> <p>Continued interview, on 02/08/13 at 3:15 PM, with the DON revealed it was not their practice to keep Baza and other lotions or creams on the bedside table in the Dementia Unit. The DON stated it was a safety concern because they had residents who were confused and wandered on the unit.</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 (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</p>	F 371	Date of Alleged Compliance	3/14/2013
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F 371	Continued From page 34 the facility's policy, it was determined the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illness. It was observed on two (2) separate occasions that food was delivered from the kitchen to a resident uncovered. The findings include: Review of the facility's policy titled, "Serving of Food and Drinks", dated 11/27/11, revealed the dietary department was responsible for delivery of the food cart to appropriate areas. Further review revealed all food items were to be covered if not delivered within a closed food cart. Observation of the resident meal cart during lunch on, 02/07/13 and 02/08/13 at 1:00 PM, revealed an open multi-tray food cart with multiple food trays was being delivered from the kitchen to the unit. On 02/07/13 one (1) of the food trays contained chocolate pudding that was uncovered. On 02/08/13 one (1) of the food trays contained a fruit cup that was not covered. Interview with Dietary Staff (SD) #16, on 02/08/13 at 1:00 PM, revealed she monitored for uncovered food items and missed covering those food items prior to them leaving the kitchen. Interview with the Food Service Manager, on 02/07/13 at 10:00 AM, revealed his expectation was that all food was covered on the open food carts that contain the residents' trays.	F 371	F-371 Florence Park Care and Rehabilitation facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. 1. There were no negative outcomes to any residents due to not covering one (1) chocolate pudding and one (1) fruit cup for distribution to residents. 2. An in-service was conducted 2/27/13 by the Director of Dietary services for all Dietary staff in regard to covering food items for transport to residents. 3. The Dietary Director / Dietary Supervisor will complete a Quality Assurance study to observe the covering of food items to ensure sanitary conditions are maintained during the distribution of food items to residents. The Q.A. studies will begin 2/25/13 and will be performed for one meal three times per week during tray set-up and delivery for one month, then once weekly for three months then quarterly X 3 to ensure that food is stored, prepared, distributed and served under sanitary conditions. The findings will be documented and presented to the Quality Assurance committee quarterly for review. 4. The Corporate Dietitian will monitor compliance monthly beginning 3/15/13 and will report findings to the Dietary Director monthly. The Dietitian / designee will report findings to the Quality Assurance committee for quarterly review. Completion Date	3/15/2013	
F 431 SS-D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431			

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F 431	Continued From page 35 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 Drug Records, Label/Store Drugs & Biologicals	
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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to ensure discontinued/expired medications were</p>		<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable as accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provided separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse</p>	
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F 431	Continued From page 36 not available for resident use. Observation of a medication cart in the Memory Unit revealed a resident had Promethazine 12.5 milligrams (mg) tablets with an expiration date of 12/25/12 in their storage compartment. In addition, a resident had Loperamide 2 mg capsules that had been discontinued. The findings include: Review of the facility's policy: "Storage of Medications", revised date April 2007, revealed the facility would store all drugs and biologicals in a safe, secure, and orderly manner. Further review of the policy revealed, under Policy Interpretation and Implementation #4, the facility would not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs were to be returned to the dispensing pharmacy or destroyed. Observation, on 02/06/13 at 3:00 PM, of a medication cart in the Memory Unit revealed a resident had Promethazine 12.5 milligrams (mg) tablets with an expiration date of 12/25/12 in their storage compartment. Continued observation revealed a resident had Loperamide 2 mg capsules that had been discontinued. The Loperamide was ordered to be given three (3) days, from 08/06/12 to 08/09/12. Interview, on 02/06/13 at 3:00 PM, with Licensed Practical Nurse (LPN) # 2 revealed the observed medications had been discontinued/expired and should not have been in the medication cart. She stated the facility process was to audit the medication cart for discontinued/expired medications. The LPN revealed when they did	F 431	Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is a minimal and a missing does can be readily detected. 1. Promethazine 12.5 mg and Loperamide 2mg were immediately pulled from cart and packaged for return to pharmacy by LPN #2. 2. Resident did not receive the promethazine or the loperamide after the expiration date. 3. A facility wide medication cart audit was conducted checking all medications for all residents by the DON, Unit Manager, Clinical Coordinator and RN Supervisor on 2/11/2013, 2/12/2013, and 2/13/2013 to ensure no expired or discontinued medications were in medication carts and to ensure no residents received any expired medications. 4. No residents received any expired medications and no residents were ill affected by the alleged deficient practice. 5. RNs, LPNs, and KMAs were educated on 3/1/2013 and 3/4/2013 by the DON on the importance of pulling medications after discontinuation, completion or upon expiration as well as the importance of checking expiration dates on any medication prior to administration.		

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F 431 Continued From page 37 medication pass they were also supposed to look to see if the medications were expired or discontinued. Continued interview with LPN revealed the concern was a potential the discontinued/expired medications may have been given to the resident.

F 431 6. Unit Manager, Clinical Coordinator (acting Unit Manager – Rehab) and RN and LPN Supervisors were in-serviced about ensuring medications are pulled with discontinuation, completion and prior to expiration on 2/11/2013 by DON.

Interview, on 02/08/13 at 3:15 PM, with the Director of Nursing (DON) revealed the Pharmacy does monthly audits to identify expired medications. The DON stated the Unit Managers were supposed to review the orders daily to identify discontinued medications and they were to have been pulled from the cart. She stated the expectation was for nurses to check the medications (to determine if discontinued/expired) when pulling the drug. Further interview with the DON revealed the concern was the discontinued drug could have been administered and the effectiveness of the expired medication.

7. QA audit will be conducted by DON or designee beginning the week of 3/4/13 on 1 medication cart a week for 12 weeks to ensure all discontinued, completed and expired medications are pulled. The results will be reported quarterly to the Quality Assurance committee for review.
8. The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

F 441 483.65 INFECTION CONTROL, PREVENT SS=F SPREAD, LINENS

F 441

Date of Alleged Compliance 3/14/2013

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.

F441 Infection Control, Prevent Spread, Linens

- (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

1. The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
(a) Infection Control Program

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F 441 Continued From page 38
actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility's policy, 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. Observations throughout the survey revealed multiple incidences of breaches in established infection control practices. These failures involved staff from the Nursing, Dietary and Environmental Services Departments. The facility's infection rate indicated a system failure;

F 441 The Facility must establish an Infection Control Program under which it

(1) Investigates, controls, and prevents infections in the facility,
(2) Decides what procedures, such as isolation, should be applied to an individual resident, and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

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F 441	Continued From page 39 however, formal tools for audits and monitoring were not utilized. Although some measures were instituted, the facility failed to develop a comprehensive approach to identify clusters and possible modes of transmission, and failed to have a system to monitor staff for adherence to infection control principles. The findings include: Review of the facility's policy titled "Infection Control Program", undated, revealed an Infection Control Committee was established and was responsible for the investigation, reporting, control and prevention of infections, all occupational exposures to blood and body fluids or other potentially infectious materials, and for monitoring staff performance to ensure that infection control policies and procedures are properly implemented. Review of the facility's policy, titled Isolation/Quarantine, updated 02/2012, revealed Disposable gowns may be indicated if rolling or coming in direct contact with the resident or a potentially contaminated environment. 1. Review of the clinical record revealed Resident #14 was admitted by the facility on 09/05/10 with diagnoses which included Morbid Obesity, Depression and Hypertension. Continued review revealed the resident was in Contact Isolation for a multi drug-resistant Urinary Tract Infection. Observation of Incontinence care, on 02/07/13 at 2:50 PM, revealed State Registered Nursing	F 441	Personnel must handle, store, process and transport linens so as to prevent the spread of infection . 1.1 DON educated related to auditing/tracking tool by Corporate Director of Clinical Services on 2/8/2013 to assist with identifying clusters and possible modes of transmission. 1) Facility printed complete copy of Infection Control Manual for each unit and director office on 2/8/2013; on line version is now available in paper print at each nursing station. 2) SRNA #8 was immediately educated by Unit Manager on 2/7/2013 on proper hand washing, changing gloves and isolation precautions. 3) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections. 4) RNs, LPNs, SRNAs and KMAs in-serviced by DON on hand washing, changing gloves, infection control manuals and isolation precautions on 2/19/2013, 3/1/2013 and 3/4/2013. 5) QA study will be conducted by DON or designee, beginning the week of 3/4/13, to monitor 5 employees a week for 12 weeks while providing care to ensure proper hand washing, changing gloves and isolation precautions are being followed during care to ensure compliance. 6) The Administrator will ensure	

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F 441 Continued From page 40
Assistant (SRNA) #8 applied gloves and cleaned Resident #2 of a large bowel movement. After completing the care, and before removing the gloves or washing her hands, the SRNA took both of the resident's hands in her own gloved hands and helped the resident turn over in the bed.

F 441 compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Interview with SRNA #8, on 02/07/13 at 3:15 PM, revealed she knew she should have switched gloves before taking the resident's hands. When questioned further about proper hand sanitation, the SRNA took a reference sheet from her pocket and pointed out hands should be washed after removing gloves and before applying new gloves.

Alleged Date of Compliance 3/14/2013

2. Observation on the Long Term care (LTC) unit, on 02/08/13 at 10:00 AM, revealed a staff member was pushing a utility cart and delivering disposable briefs to resident rooms. The employee carried the briefs into each room, opened the cabinets above the sinks, and stocked the cabinets with the briefs. Continued observation revealed the staff did not wear gloves, or wash or sanitize his hands between rooms, including three (3) rooms on the hall with contact isolation procedures in place. In each room, the staff member touched the cabinet door handles, which were potentially contaminated by other staff during the provision of resident care.

1.2 Central supply staff member was immediately educated by DON on 2/8/2013 on proper hand washing, donning gloves and isolation precautions while delivering briefs in isolation rooms along with provided education proper removal and handling of potentially contaminated items.

- 1) No residents showed ill effects from alleged deficient practice as evidenced by no new infections.
- 2) All staff were in-serviced by DON on hand washing, changing gloves, infections control manuals and isolation precautions on 3/1/13 and 3/4/13.
- 3) A QA will be conducted by DON or designee, beginning the week of 3/4/13, on non-nursing staff 2 times a week for 12 weeks to ensure all staff is washing hands, donning gloves and following the isolation policy to ensure compliance.
- 4) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance 3/14/2013

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F 441	Continued From page 41 revealed he had not considered the cabinet door handles could be contaminated. 3. Interview with Unsampled Resident B, on 02/07/13 at 3:25 PM, revealed the resident had concerns related to infection control. The resident stated his/her roommate was in isolation and sometimes he/she went on the other side of the room to adjust the heat. Unsampled Resident B further stated he/she had never been educated on what, if any, measures to take for protection from the roommate's infection. Interview with the Unit Manager (UM), on 02/08/13 at 4:30 PM, revealed it was the responsibility of the Charge Nurse or the UM to educate the roommate of a resident in isolation when appropriate. She stated there was no monitoring system in place to ensure this was done. Interview with the DON, on 02/08/13 at 6:10 PM, revealed no one person was designated to educate residents about safe practices if their roommate was in isolation. She stated the UM, the Charge Nurse or the DON should provide the education. She further stated the facility tried to educate every resident as needed, but there was no formal process for providing or documenting the education, and no audit to ensure this was being done. 4. Observation during the noon meal service, on 02/05/13 at 12:50 PM, revealed a resident sitting in a wheelchair at the dining table in the Long Term Care dining room. Continued observation revealed the resident had a catheter drainage bag hanging underneath the chair and lying	F 441	1.3 Un-sampled resident B show no ill effects from the alleged deficient practice. Resident B was immediately educated on 2/7/2013 by the unit manager about importance of washing hands and infection control practices. 1) Education offered to residents, roommates and families of those individuals noted with an infectious disease on 2/11/2013, 2/12/2013, and 2/13/2013. 2) RNs and LPN were in-serviced on 2/12/2013, 3/1/2013 and 3/4/2013 by the DON on educating residents, roommates, families and visitors on the importance of washing hands and any possible isolation precautions. 3) DON and Unit Managers were in-serviced on the infection control monitoring sheet by the Corporate Director of Clinical services on 2/11/2013. 4) A QA will be conducted in the form of an infection control monitoring sheet ensuring roommates and families of residents with infectious diseases are educated on proper infection control techniques beginning the week of 3/4/13. This will be completed by the unit manager with each new infection requiring isolation and monitored by the director of nursing weekly. 5) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.		

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F 441	Continued From page 42 directly on the floor. Subsequent observation, on 02/05/13 at 1:15 PM, revealed the resident was pushed to the sitting area by staff, with the catheter bag dragging the floor.	F 441	Alleged Date of Compliance	3/14/2013	
	<p>Interview with Licensed Practical Nurse (LPN) #13, on 02/05/13 at 1:20 PM, revealed the catheter bag should not have been dragging the floor. Further interview revealed the resident was currently being treated for a multi-drug resistant Urinary Tract Infection.</p> <p>Interview with SRNA #6, on 02/05/13 at 6:15 PM, revealed she was assigned to care for the resident on the day of the observation. She stated she she did not get the resident up that morning and wasn't sure who did, and she had not realized the resident's catheter bag was dragging on the floor at lunchtime. Continued interview revealed the SRNA knew the catheter bag could not be on the floor and she tried to secure the bag under the chair in a manner that prevented it from dragging.</p> <p>Interview with the Unit Manager, on 02/08/13 at 2:00 PM, revealed catheter bags should not be allowed to touch or drag on the floor, as it was an infection control concern.</p> <p>5. Observation, on 02/07/13 at 11:36 AM, revealed LPN #10 removed her gloves but failed to wash her hands after performing blood glucose monitoring. The LPN exited the resident's room, placed the glucose monitoring device on a paper towel on top of the medication cart, withdrew insulin from a vial, donned gloves, administered the insulin to the resident, removed the gloves without washing her hands, exited room into the hall, and placed the unwashed glucometer on top</p>		<p>1.4 Residents catheter tubing was immediately secured to prevent touching the floor on 2/5/2013 by Unit Manager.</p> <ol style="list-style-type: none"> 1) A Facility Audit was conducted on 2/6/2013 to ensure catheter tubing was secured and not touching the floor by DON, Unit Manager and Clinical Coordinator. 2) DON updated the catheter policy to include securing catheter tubing on 2/25/2013. 3) Immediately in-services LPN 13 and SRNA 6 by Unit Manager to ensure all catheter tubings are secure and does not touch floor at any time. 4) No resident showed any ill effects from the alleged deficient practice as evidenced by no new infections. 5) RNs, LPNs, KMAs, and SRNAs were in-serviced by DON on 3/1/2013 and 3/4/2013 to ensure all catheter tubing is secure and does not touch to floor at any time and Catheter Policy updated 2/25/2013. 6) A QA will be conducted by the DON or designee, beginning the week of 3/4/13 on 5 residents a week for 12 weeks to ensure all catheter tubing is secured and not touching the floor. 7) The Administrator will ensure compliance through review and evaluation of the effectiveness of the 		

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F 441 Continued From page 43
of an open basket of unused lancets and strips.
Interview with LPN #10, on 02/07/13 at 11:45 AM, revealed she did not think about contamination of the lancets and strips, and she should have

F 441 implemented system changes and Quality Assurance studies.
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cleaned the glucometer prior to putting it in the basket. She stated the lancets and strips would be discarded. Further interview revealed she should have washed her hands after she removed the gloves, but stated she was nervous.

1.5 LPN #10 was immediately educated by Clinical Coordinator on 2/7/2013, related cleansing of gluco-meter, washing hands and infection control. The lancets, gluco-meter strips and basket were immediately discarded on 2/7/2013 and not used.

Interview with the Clinical Coordinator, on 02/08/13 at 4:14 PM, revealed staff should always wash their hands after taking gloves off, and prior to exiting the room. She stated the nurse should have washed her hands after taking the gloves off and should have cleaned the glucometer prior to placing it in the basket of lancets and strips. Further interview revealed the facility had to discard the lancets and strips due to contamination. She stated it was an Infection Control issue.

1) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections.
2) RNs and LPNs were in-serviced by DON on 3/1/2013 and 3/4/2013 related to cleansing of gluco-meter, washing hands and infection control.

Interview with the Unit Manager (UM), on 02/08/13 at 6:30 PM, revealed the nurse should have washed her hands after removing the gloves and should have cleaned the glucometer before putting it in the basket. She stated it was an Infection Control issue and staff was in-serviced on Infection Control.

3) A QA will be conducted by DON / designee, beginning the week of 3/4/13, monitoring 5 employees a week for 12 weeks to ensure proper gluco-meter cleansing, hand washing and infection control.

6. Review of the facility's policy, "Assisting with Meals", undated, revealed all employees who provide resident assistance with meals would be trained and should demonstrate competency in the prevention of food borne illness, including personal hygiene practices and safe food handling.

4) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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1.6 MDS nurse and SRNA #24 were immediately educated on 2/5/2013 by DON related using utensils to cut residents

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Observation of lunch service in the main dining room, on 02/05/13 at 12:18 PM, 12:49 PM, and at 12:53 PM, revealed the Minimum Data Set (MDS) Nurse touched multiple residents' food with her bare hands while she assisted them with their trays. The MDS Nurse was observed touching residents' bread/rolls when she cut or helped prepare their food.

Interview, 02/05/13 at 1:15 PM, with Licensed Practical Nurse (LPN) #5 revealed staff was trained on tray service and meal preparation. She stated staff was not supposed to touch the food with their bare hands because it was an infection control issue.

Interview, on 02/05/13 at 1:25 PM, with the MDS Nurse revealed she was touching the residents' food when cutting/helping residents with their sandwiches. The nurse stated she did not think it was an infection control issue because she had used a hand sanitizer before she touched the food. Further interview revealed she was unsure what the facility's policy was about touching food with bare hands.

Observation of the noon meal service in the Long Term Care dining room, on 02/05/13 at 1:30 PM, revealed State Registered Nurse Aide (SRNA) #24 handled a resident's bread with her bare hands. The SRNA placed the croissant top on the resident's sandwich, then held the sandwich with her bare hand while cutting it into two pieces.

During interview with SRNA #24, on 02/05/13 at 6:10 PM, she stated she normally used utensils for handling bread, but she had to use her hand to keep the sandwich lid from falling off at the

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food and if need to touch food wash hands and don gloves prior to touching food.
1) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections.
2) RNs, LPNs, KMAs and SRNAs were in-serviced by DON on 3/1/2013 and 3/4/2013 on Assisting with meals and using utensils to cut residents food and if need to touch food wash hands and don gloves prior to touching food.
3) A QA will be conducted by the DON or designee, to begin during the week of 3/4/13 on 2 meals a week for 12 weeks to ensure utensils are being utilized to cut food and if staff needs to touch food wash hands and don gloves prior to handling food.
4) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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1.7 MDS nurse immediately placed isolation sign on doorway to room 111 on 2/8/2013.
1) No residents show ill effects from the alleged deficient practice as evidenced by no new infections.
2) A house wide audit was conducted to ensure all isolation rooms have an isolation sign posted at doorway on 2/9/2013 by DON, Unit Manager, and

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F 441 Continued From page 45
time of the observation. She further stated she did not recall any specific training about handling food without gloves and no one had ever mentioned it to her.

F 441 3) Clinical Coordinator, DON and Unit Managers were in-serviced on the infection control monitoring sheet by the Corporate Director of Clinical services on 2/1/2013.

Interview with the DON, on 02/08/13 at 3:15 PM, revealed it was not facility practice to allow staff to touch food with their bare hands. The nurses monitored for infection control during meal service and if they saw something they were to address the issue. The safety concern related to staff touching food was infection control. Continued interview revealed everyone received training on food service. She stated she thought the Dietary Manager covered this during inservice.

7. Observation, on 02/08/13 of room 203 at 9:55 AM and room 111 at 11:05 AM, revealed both rooms had an isolation box on the door, but no sign indicating visitors should stop and see the nurse prior to entering the room.

Interview, on 02/08/13 at 9:55 AM, with SRNA #3 revealed room 203 was supposed to have a stop sign on the door. She stated the absence of the sign was a concern because visitors would not know to stop and see the nurse and would not receive instruction regarding necessary infection control procedures.

Interview, on 02/08/13 at 11:05 AM, with SRNA #5, who worked on the memory unit, revealed room 111 had no sign on the door to stop and see the nurse.

Interview with LPN #10, on 02/08/13 at 11:50 AM, revealed nurses were to educate those who

4) RNs and LPNs were in-serviced by DON on 2/19/2013, 3/1/2013 and 3/4/2013 related to importance of ensuring isolation signs are posted in the doorway of all isolation rooms.

5) A QA will be conducted in the form of an infection control monitoring sheet ensuring isolation signs are posted at the doors for each resident in isolation. This will be completed by the unit manager with each new infection requiring isolation and monitored by the director of nursing weekly.

6) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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1.8 SRNA #10 was immediately educated related proper hand washing and changing gloves on 2/6/2013 by Unit Manager.

1) Unit Manager immediately changed the blanket for Resident #10.

2) Resident #10 showed no ill effects from the alleged deficient practice as evidenced by no new infections.

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visited residents in isolation on infection control practices such as handwashing and the stop signs on the door were important to let visitors know they needed to see the nurse before entering the room.

Interview with LPN #7, on 02/08/13 at 2:30 PM, revealed she was the Week-end Supervisor/Charge Nurse. She stated rooms with isolation boxes on the door were supposed to have a stop sign directing the visitor to see the nurse before entering the room. She stated the signs were in place to inform visitors and other residents to see the nurse so they could be educated on how to protect themselves and the residents.

Interview with the UM, on 02/08/13 at 4:30 PM, revealed stop signs were utilized to inform other residents and visitors to ask the nurse about infection control. The LPN stated the Charge Nurse, Unit Managers, and the Central Supply person were supposed to ensure the signs were on the doors. She stated the facility became aware all isolation rooms did not have signs after the survey team entered the building. The LPN stated by not having the signs on the doors the facility was not following their infection control practices, which increased the risk of possible organism transmission.

8. Observation of perineal care for Resident #7, on 02/06/13 at 2:30 PM, revealed SRNA #10 cleansed the perineal area from front to back with a warm wet wash cloth, and proceeded to wash the anal area with another warm wash cloth. Continued observation revealed she placed the resident's soiled brief in one bag and the soiled wash cloths in another bag at the end of the bed.

- F 441
- 3) RNs, LPNs, SRNAs were in-serviced by DON on proper peri-care, hand washing and changing gloves on 3/1/2013 and 3/4/2013.
 - 4) A QA will be conducted by DON or designee to monitor 5 employees a week for 12 weeks while providing care to ensure proper hand washing, changing gloves and isolation precautions are being followed during care.
 - 5) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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- 1.9 SRNA #17 was immediately educated on 2/5/2013 by Clinical Coordinator on isolation policy, donning gowns.
- 1) Resident #12 showed no ill effects from the deficient practice as evidenced by no new infections.
- 2) A QA will be conducted by DON or designee to monitor 5 employees a week for 12 weeks while providing care to ensure proper hand washing, changing gloves and isolation precautions are being followed during care.
- 3) Maintenance Director was immediately in-serviced on 2/9/2013 by DON r/t proper removal and packaging of isolation boxes.
- 4) No residents showed ill effects from alleged deficient practice.
- 5) All staff was in serviced by DON

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SRNA #10 then placed a new brief on the resident and pulled the resident's blanket up with the same soiled gloves, without removing the gloves and washing her hands.

F 441 2/19/2013, 3/1/2013, and 3/4/2013 on proper handling of potentially contaminated items.
6) A QA will be conducted by DON or designee on non-nursing staff 2 times a week for 12 weeks to ensure all staff is washing hands, donning gloves, proper handling of potentially contaminated items and following the isolation policy.
7) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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Interview with SRNA #10, on 02/06/13 at 2:45 PM, revealed she realized that she should have removed her gloves and washed her hands after completing the perineal care and before covering the resident.

Interview with LPN #6, on 02/06/13 3:00 PM, revealed SRNA #10 should have changed her gloves. She stated staff had been educated regarding proper use of gloves and hand washing and the SRNA should have known better.

9. Observation, on 02/05/13 at 6:15 PM, revealed SRNA #17 was assisting Resident #12, who was in contact isolation, with his/her meal. SRNA #17 was wearing gloves with no isolation gown on. SRNA #17 was leaning into Resident #12's bed to assist with the meal and her uniform pants and shirt came into contact with the potentially infectious linen and gown of Resident #12.

Interview with the DON, on 02/08/13 at 6:20 PM, revealed staff should always wear a gown and gloves anytime there was a potential of touch a resident in contact isolation or any other contaminated surface. She further stated this would included possible contact while feeding a resident.

10. Review of the facility's policy titled "Medical Waste Containers", undated, revealed medical waste containers used by the facility should be constructed to contain all contents and prevent leakage of fluids during handling, storage,

1.10 Facility audit was conducted by the Directors 2/7/2013 to ensure privacy curtains did not touch bio-hazard boxes or any isolation supplies and all isolation supplies were placed on the side of the resident's room requiring the isolation precautions.

- 1) Facility replaced cardboard bio-hazard boxes with smaller more compact containers for potentially contaminated laundry and trash and removed the bio-hazard boxes from the isolation rooms.
- 2) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections.
- 3) Resident #8 showed no ill effects from the alleged deficient practice.
- 4) All staff was in-serviced 3/1/2013, and 3/4/2013 by DON on proper placement

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F 441	Continued From page 48 transport or shipping. It further stated the containers should be closed prior to removal from facility, treatment areas, resident rooms or from the premises to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. In addition, it stated the containers should be impermeable and capable of maintaining impermeability through final waste disposal. Observation of the Director of Maintenance/Housekeeping/Laundry, on 02/09/13 at 2:30 PM, revealed he was working in the Soiled Utility Room and was packing infectious hazardous waste bags into boxes without a wearing an isolation gown. Observation during the initial tour, on 02/05/13 at 9:45 AM, revealed a hazardous medical waste box and an infectious soiled linen box as well as a bedside toilet were located in a semi-private room on the side of the room with the non-infectious resident. Both boxes were touching the privacy curtain and part of the curtain was inside of the infectious waste bag. Observation, on 02/05/13 at 5:20 PM, 02/06/13 at 10:30 AM and 02/07/13 at 2:10 PM, revealed Resident #8's privacy curtain was hanging inside of the infectious waste box and in contact with the contents of the box. Interview with LPN #11, on 02/05/13 at 9:45 AM, revealed the resident in contact isolation was mobile and pushed the boxes out of her/his way. Further interview with LPN #11 revealed the boxes and the toilet should remain on the side of the room of the resident in isolation.	F 441	and handling of potentially contaminated items. 5) A QA will be conducted by DON or designee on non-nursing staff 2 times a week for 12 weeks to ensure all staff is washing hands, donning gloves, proper handling of potentially contaminated items and following the isolation policy. 6) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies. 7) Alleged Date of Compliance	3/14/2013	
			1.11 SRNA #21 was immediately educated r/t isolation policy, washing hands, donning gloves and gowns by Unit Manager. 1) Resident #21 showed no ill effect from the alleged deficient practices as evidenced by no new infections. 2) RNs, LPNs, SRNAs were in-serviced by DON related to isolation policy and donning gowns on 2/19/2013, 3/1/2013 and 3/4/2013. 3) A QA will be conducted by DON or designee to monitor 5 employees a week for 12 weeks while providing care to ensure proper hand washing, changing gloves and isolation precautions are being followed during care. 4) The Administrator will ensure compliance through review and evaluation of the effectiveness of the		

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F 441	Continued From page 49 Observation, on 02/07/13 at 11:20 AM, revealed Central Supply staff removed a hazardous medical waste bag from the bio-hazard box in an isolation room. Central Supply staff lifted the hazardous waste bag over a non-infectious resident's bed. The staff member proceeded to carry the medical waste bag down the hall without being contained in the bio-hazard box. In addition, observation revealed the staff was not wearing a protective gown. Interview with the DON, on 02/08/13 at 6:10 PM, revealed the hazardous waste and linen boxes as well as the bed side toilet should remain on the side of the room with the infected resident due to potential for cross contamination. Interview further revealed the hazardous waste and linen bags should not have been lifted over a resident's clean bed and the contents should have been contained inside the bags, within the bio-hazard boxes due to potential for cross contamination. Additionally the DON stated that all staff should wear isolation gowns when packing the bio-hazardous boxes for transport. The DON further stated that all staff should adhere to the facility's infection control policy. 11. Record review revealed Resident #21 was admitted by facility on 02/07/13 with diagnoses which included Clostridium Difficile (C-diff) Infection, Diabetes Type II, Depression and Anxiety. Review of Resident #21's Physician's Orders, dated 02/07/13, revealed the Resident was currently prescribed Vancomycin (Antibiotic) 250 milligrams by mouth every six (6) hours for seven (7) days to treat C-diff. Further review of the	F 441	implemented system changes and Quality Assurance studies. (5) Alleged Date of Compliance	3/14/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/10/2013
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 50 Physician' Orders revealed an order which indicated Resident #21 was to be placed on isolation for C-diff. Observations of Resident #21, on 02/08/13 at 1:40 PM, revealed there was a stop sign on the Resident's room door, with an isolation kit that included disposable gloves and gowns. Inside Resident #21's room there was a yellow bag isolation box, as well as a red bag isolation box at the foot of his/her bed. During this observation SRNA #21 entered Resident #21's room and did not gown or glove prior to entering. SRNA #21 walked over to Resident #21's side and placed a styrofoam tray on the overbed table. While doing so, she moved the resident's water pitcher to side of table. Then SRNA #21 touched the resident's drinking cup (which he/she had been using prior) and then adjusted Resident #21's TV. After touching the TV, SRNA #21 applied hand sanitizer from her pocket and proceeded with tray set-up. Once the tray was set-up SRNA #21 touched Resident #21's arm/back several times to cue him/her to eat, and assisted him/her with feeding. The SRNA placed her hand on her shirt/uniform after direct contact with Resident #21. Interview with SRNA #21, on 02/08/13 at 1:45 PM, revealed she knew Resident #21 was admitted with C-diff and due to this was on contact precautions. SRNA #21 further reported she was to wear gloves and a gown when in direct contact with residents in contact isolation. She stated she should have donned gloves and a gown prior to touching Resident #21. Interview with LPN #10, on 02/08/13 at 2:30 PM,	F 441			

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F 441	Continued From page 51 revealed staff was expected to wear gowns and gloves when in direct contact with residents including during feeding. Interview with the Long Term Care (LTC) Unit Manager (UM), on 02/08/13 at 4:30 PM, revealed she knew infections had been a problem, but she was not kept informed of infections in the facility. She further stated formal auditing of infection control practices could be helpful in determining how an infection was acquired. In addition, assuring proper procedures were being followed would help to minimize the risk of cross-contamination of non-infected residents. Further Interview with the DON, on 02/08/13 at 6:10 PM, revealed she did random observations of infection control practices in the facility but did not record her findings. The DON reported she and the UMs "watch and monitor" but did not perform a formal audit or use an auditing tool. She stated, "we don't always write it down". Subsequent interview with the DON, on 02/10/13 at 12:45 PM, revealed she had attended infection control seminars but was not a certified infection control nurse. She stated she had access to the infection control manual and online resources but had not received formal training on using the corporate infection control software or auditing tools. During continued interview, the DON provided evidence of infection control inservices, but acknowledged there had been no followup audits to ensure the training was effective. Interview with the corporate Director of Clinical Services (DCS), on 02/09/13 at 5:05 PM, revealed concerns about the number of infections at the facility had been identified at the corporate	F 441			

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F 441 Continued From page 52
level several months ago. She stated several interventions had been put in place, including a defogger for disinfection when a resident came out of isolation, hands-free sanitizers to be used in isolation rooms, and new door-mounted

F 441 **F - 490 Effective Administration / Resident Well-Being**
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

F 490
SS=F 483.75 EFFECTIVE
ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

F 490
1.1 DON educated related to auditing/tracking tool by Corporate Director of Clinical Services on 2/8/2013 to assist with identifying clusters and possible modes of transmission.
1) Facility printed complete copy of Infection Control Manual for each unit and director office on 2/8/2013; on line version is now available in paper print at each nursing station.
2) SRNA #8 was immediately educated by Unit Manager on 2/7/2013 on proper hand washing, changing gloves and isolation precautions.
3) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections.
4) RNs, LPNs, SRNAs and KMAs inserviced by DON on hand washing, changing gloves, infection control manuals and isolation precautions on 2/19/2013, 3/1/2013 and 3/4/2013.
5) A weekly meeting will be held beginning the week of 3/24/13 with the Administrator, DON/designee, Director of Environmental Services, Dietary

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A high number of urinary tract infections caused by multi-drug resistant organisms was identified at the facility. Observations revealed multiple instances of inadequate infection control practices by Nursing, Dietary and Environmental Services Departments. In addition, the facility did not have adequate Quality Assurance (QA)

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F 490	Continued From page 53 activities to identify potential sources of infection and did not develop a plan of action to address the issues. Refer to F 441 and F 520. The findings include:	F 490	Director, Social Services Director, Activities Director and Marketing and Admissions Director. The weekly meeting will review the prior week's audit results. During the meeting, department directors will be evaluating systems, policy compliance and effectiveness. As issues and or trends are identified, a root cause analysis will be conducted, and if necessary, new measures and system changes will immediately be implemented which will include, but not limited to staff training and then monitored for effectiveness. Results of the audits will be presented to the Medical Director by the Administrator on a monthly basis, beginning the week of 3/24/13, to evaluate the effectiveness of new systems, policies and audit results. In conjunction with the Medical Director, the Administrator will work with department directors to implement any necessary system changes.	
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	<p>According to the "Isolation / Quarantine" policy, undated, the facility would endeavor to practice infection control guidelines to prevent the acquisition and spread of infectious disease. Continued review revealed contact isolation was designed to prevent transmission of highly transmissible infections. Specific procedures included the following: gloves are indicated when providing personal care; staff are to wear a gown if they anticipate direct contact with the resident or the environment; and hands must be washed after touching the resident or the environment, as it is potentially contaminated.</p> <p>During the survey, multiple residents were under contact isolation procedures due to infections with multi-drug resistant organisms. Numerous breaches of infection control precautions were observed and included but were not limited to the following: staff from Nursing, Dietary, and Environmental Services Departments entered isolation rooms and made contact with infected residents or potentially contaminated surfaces without wearing proper protective equipment (gowns and gloves) and without washing their hands prior to exit and before entering other resident rooms; biohazard containers were observed on the wrong side of semi-private rooms, i.e. on the side of the non-infected resident; biohazard trash and linens were not handled in a manner to prevent cross-contamination of other surfaces; staff</p>		<p>6) The DON, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director, Marketing and Admissions Director, Dietitian, Medical Director, and the Facility Rehab Coordinator will participate in a quarterly QA meeting which will be led by the Administrator to evaluate systems and their effectiveness which will include, but not limited to the following: QA will be conducted by DON or designee, beginning the week of 3/4/13 to monitor</p>	
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F 490 Continued From page 54 touched residents' food with their bare hands, and uncovered food was delivered to the units on open carts; and catheter bags were observed to be lying or dragging on the floor. Refer to F 441 in the Statement of Deficiency for additional information and details of the deficient practice.

Review of the policy titled "Continuous Quality Improvement Program", undated, revealed "data collected about aspects of care and services (through the use of indicators) is monitored and assessed regularly to determine whether desired outcomes are reached". Continued review revealed the Continuous Quality Improvement committee was responsible for developing a quality improvement plan that established indicators and thresholds, a system for conducting audits, and a tracking system for follow-through and monitoring of action plans and improvement. Refer to F 520 in the Statement of Deficiency for details of the deficient practice.

Interview with the corporate Director of Clinical Services (DCS), on 02/09/13 at 5:05 PM, revealed concerns about the number of infections at the facility had been identified at the corporate level several months ago. She stated several interventions had been put in place, including a fogger for disinfection when a resident came out of isolation, hands-free sanitizers to be used in isolation rooms, and new door-mounted isolation packs containing protective equipment, e.g. gowns and gloves, had been purchased for use at the facility. She further stated there was a formal mechanism for tracking and trending infections, but acknowledged facility Administration had not been using it fully for maximum benefit.

F 490 5 employees a week for 12 weeks while providing care to ensure proper hand washing, changing gloves and isolation precautions are being followed during care to ensure compliance.

If patterns and or trends are noted, systems will immediately be analyzed and any necessary changes implemented. Staff will be in-serviced on the changes and then be monitored for their effectiveness.
7) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance 3/24/2013

1.2 Central supply staff member was immediately educated by DON on 2/8/2013 on proper hand washing, donning gloves and isolation precautions while delivering briefs in isolation rooms along with provided education proper removal and handling of potentially contaminated items.

- 1) No residents showed ill effects from alleged deficient practice as evidenced by no new infections.
- 2) All staff were in-serviced by DON on hand washing, changing gloves, infection control manuals and isolation precautions on 3/1/13 and 3/4/13.
- 3) A weekly meeting will be held beginning the week of 3/24/13 with the

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F 490	Continued From page 55 Interview with the Director of Nursing (DON), on 02/08/13 at 6:10 PM, revealed she received a monthly report from the contracted laboratory service, MedLab. The report summarized the number of infections identified by culture, and specified the organism. No other information, e.g. resident names or room numbers was included in the summary. She stated she looked at the residents when their cultures came back, and took a mental note of room numbers, but did not utilize a formal tool for identifying clusters. Continued interview revealed she presented the number of infections to the QA committee, but did not keep records of individual residents' history of infections or specific organisms. On further interview, the DON stated the facility tested more and used contact isolation more than other facilities in an effort to reduce the number of infections. She stated she did random observations of infection control practices in the facility but did not record her findings. Interview with the Administrator, on 2/10/13 at 2:15 PM, revealed he started at the facility in October 2012 and there had been only one (1) QA meeting since his arrival. He stated he was aware there was a high rate of infection, based on the numbers he heard at the QA meeting in November 2012. He stated there was not one person whose sole responsibility was infection control, this duty was assigned to the Director of Nursing. He further stated he assumed tracking and trending was being done, but realized it had not been carried far enough. Continued interview revealed the Administrator knew there was some monitoring occurring, but he did not know exactly how the data was collected and recorded. The	F 490	Administrator, DON/designee, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director and Marketing and Admissions Director. The weekly meeting will review the prior week's audit results. During the meeting, department directors will be evaluating systems, policy compliance and effectiveness. As issues and or trends are identified, a root cause analysis will be conducted, and if necessary, new measures and system changes will immediately be implemented which will include, but not limited to staff training and then monitored for effectiveness. Results of the audits will be presented to the Medical Director by the Administrator on a monthly basis, beginning the week of 3/24/13, to evaluate the effectiveness of new systems, policies and audit results. In conjunction with the Medical Director, the Administrator will work with department directors to implement any necessary system changes. 4) The DON, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director, Marketing and Admissions Director, Dietitian, Medical Director, and the Facility Rehab Coordinator will participate in a quarterly QA meeting which will be led by the Administrator to evaluate systems and their effectiveness which will include, but not limited to the following: QA will be		

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F 490 Continued From page 56
Administrator acknowledged the QA process had not been carried through as it related to the facility's infection rate. He stated he should have known more but just had not been with the facility long enough.

F 490 conducted by DON or designee, beginning the week of 3/4/13 on non-nursing staff 2 times a week for 12 weeks to ensure all staff is washing hands, donning gloves and following the isolation policy to ensure compliance.

F 520 483.75(o)(1) QAA
SS=F COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

F 520 If patterns and or trends are noted, systems will immediately be analyzed and any necessary changes implemented. Staff will be in-serviced on the changes and then be monitored for their effectiveness.
5) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

Alleged Date of Compliance 3/24/2013

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.

1.3 Unsampled resident B show no ill effects from the alleged deficient practice. Resident B was immediately educated on 2/7/2013 by the unit manager about importance of washing hands and infection control practices.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

1) Education offered to residents, roommates and families of those individuals noted with an infectious disease on 2/11/2013, 2/12/2013, and 2/13/2013.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

2) RNs and LPN were in-serviced on 2/12/2013, 3/1/2013 and 3/4/2013 by the DON on educating residents, roommates, families and visitors on the importance of washing hands and any possible isolation precautions.

This REQUIREMENT is not met as evidenced by:

3) DON and Unit Managers were in-

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F 520 Continued From page 57
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have a Quality Assurance (QA) Program which identified what quality assessment and assurance activities were

necessary, and failed to develop and implement an appropriate action plan to correct deficiencies. The facility failed to ensure the policy and procedure was implemented related to Quality Assurance. Multiple residents on all units were identified as having multi-drug resistant infections. Observations throughout the survey revealed numerous breaches in appropriate infection control practices in the provision of care for the infected residents. These breaches involved staff from several different departments, including Nursing, Dietary, and Environmental Services. The facility did not have, or was not utilizing, tools to monitor, track and trend the infections. In addition, there was no documented evidence of audits to ensure proper procedures were being followed and no evidence the QA Committee was involved in ongoing infection control monitoring in the facility. Refer to F 441.

The findings include:
According to the "Isolation/Quarantine" policy, undated, the facility would endeavor to practice infection control guidelines to prevent the acquisition and spread of infectious disease. Continued review revealed contact isolation was designed to prevent transmission of highly transmissible infections. Specific procedures included the following: gloves were indicated when providing personal care; staff was to wear a gown if they anticipate direct contact with the resident or the environment; and hands must be

F 520 serviced on the infection control monitoring sheet by the Corporate Director of Clinical services on 2/11/2013.

4) A weekly meeting will be held beginning the week of 3/24/13 with the Administrator, DON/designee, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director and Marketing and Admissions Director. The weekly meeting will review the prior week's audit results. During the meeting, department directors will be evaluating systems, policy compliance and effectiveness. As issues and or trends are identified, a root cause analysis will be conducted, and if necessary, new measures and system changes will immediately be implemented which will include, but not limited to staff training and then monitored for effectiveness. Results of the audits will be presented to the Medical Director by the Administrator on a monthly basis, beginning the week of 3/24/13, to evaluate the effectiveness of new systems, policies and audit results. In conjunction with the Medical Director, the Administrator will work with department directors to implement any necessary system changes.

5) The DON, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director, Marketing and Admissions Director, Dietitian, Medical Director, and the

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F 520	Continued From page 58 washed after touching the resident or the environment, as it is potentially contaminated. Review of the policy titled "Continuous Quality Improvement Program", updated, revealed "data collected about aspects of care and services (through the use of indicators) was monitored and assessed regularly to determined whether desired outcomes were reached". Continued review revealed the Continuous Quality Improvement Committee was responsible for developing a quality improvement plan that established indicators and thresholds, a system for conducting audits, and a tracking system for follow-through and monitoring of action plans and improvement. During the survey, multiple residents were under contact isolation procedures due to infections with multi-drug resistant organisms. Numerous breaches of infection control precautions were observed and included but were not limited to the following: staff from Nursing, Dietary, and Environmental Services Departments entered isolation rooms and made contact with infected residents or potentially contaminated surfaces without wearing proper protective equipment (gowns and gloves) and without washing their hands prior to exit and before entering other resident rooms; biohazard containers were observed on the wrong side of semi-private rooms, i.e. on the side of the non-infected resident; biohazard trash and linens were not handled in a manner to prevent cross-contamination of other surfaces; staff touched residents' food with their bare hands, and uncovered food was delivered to the units on open carts; and catheter bags were observed to	F 520	Facility Rehab Coordinator will participate in a quarterly QA meeting which will be led by the Administrator to evaluate systems and their effectiveness which will include, but not limited to the following: QA will be conducted in the form of an infection control monitoring sheet ensuring room mates and families of residents with infectious diseases are educated on proper infection control techniques, beginning the week of 3/4/13. This will be completed by the unit manager with each new infection requiring isolation and monitored by the director of nursing weekly. If patterns and or trends are noted, systems will immediately be analyzed and any necessary changes implemented. Staff will be in-serviced on the changes and then be monitored for their effectiveness. 6) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies. Alleged Date of Compliance 3/24/2013 1.4 Residents catheter tubing was immediately secured to prevent touching the floor on 2/5/2013 by Unit Manager. 1) A Facility Audit was conducted on 2/6/2013 to ensure catheter tubing was secured and not touching the floor by		

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F 520 Continued From page 59
be tying or dragging on the floor. Refer to F 441

Interview with the Long Term Care (LTC) Unit Manager (UM), on 02/08/13 at 4:30 PM, revealed ~~she knew infections had been a problem~~, but she was not kept informed of infections in the facility. She stated she was not aware of any standardized audits related to infection control. She further stated formal auditing of infection control practices could be helpful in determining how an infection was acquired. In addition, assuring proper procedures were being followed would help to minimize the risk of cross-contamination of non-infected residents.

Interview with the Director of Nursing (DON), on 02/08/13 at 6:10 PM, revealed she received a monthly report from the contracted laboratory service, MedLab. The report summarized the number of infections identified by culture, and specified the organism. No other information, e.g. resident names or room numbers was included in the summary. She stated she looked at the residents when their cultures came back, and took a mental note of room numbers, but did not utilize a formal tool for identifying clusters. Continued interview revealed she presented the number of infections to the QA committee, but did not keep records of individual residents' history of infections or specific organisms. On further interview, the DON stated the facility tested more and used contact isolation more than other facilities in an effort to reduce the number of infections. She stated she did random observations of infection control practices in the facility but did not record her findings. The DON reported she and the UMs "watch and monitor" but do not perform a formal audit or use an

F 520 DON, Unit Manager and Clinical Coordinator.

- 2) DON updated the catheter policy to include securing catheter tubing on 2/25/2013.
- 3) Immediately in-services LPN 13 and SRNA 6 by Unit Manager to ensure all catheter tubings are secure and does not touch floor at any time.
- 4) No resident showed any ill effects from the alleged deficient practice as evidenced by no new infections.
- 5) RNs, LPNs, KMAs, and SRNAs were in-serviced by DON on 3/1/2013 and 3/4/2013 to ensure all catheter tubing is secure and does not touch to floor at any time and Catheter Policy updated 2/25/2013.
- 6) A weekly meeting will be held beginning the week of 3/24/13 with the Administrator, DON/designee, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director and Marketing and Admissions Director. The weekly meeting will review the prior week's audit results. During the meeting, department directors will be evaluating systems, policy compliance and effectiveness. As issues and or trends are identified, a root cause analysis will be conducted, and if necessary, new measures and system changes will immediately be implemented which will include, but not limited to staff training and then monitored for effectiveness. Results of the audits will be presented to

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520 Continued From page 60 auditing tool. She stated, "we don't always write it down".

Interview with the corporate Director of Clinical Services (DCS), on 02/09/13 at 5:05 PM, revealed concerns about the number of infections at the facility had been identified at the corporate level several months ago. She stated several interventions had been put in place, including a defogger for disinfection when a resident comes out of isolation, hands-free sanitizers to be used in isolation rooms, and new door-mounted isolation packs containing protective equipment, e.g. gowns and gloves, had been purchased for use at the facility. She further stated there was a formal mechanism for tracking and trending infections, but acknowledged the facility had not been using it fully for maximum benefit.

Interview with the Medical Director (MD), on 02/09/13 at 5:30 PM, revealed he was actively involved in the QA committee. He stated "numbers" related to cases of infection were reported at the committee meetings, but he had not seen any tracking forms. He further stated he had recognized an increase in urinary tract infections and had initiated a new policy for obtaining a urinalysis upon admission for all new residents, to determine whether or not the infections were acquired at the facility or prior to admission. During continued interview, the MD stated if standard and isolation precautions were followed diligently, it should suffice to prevent transmission from one resident to another. He further stated audits could be useful in reducing the risk of cross-contamination.

Subsequent interview with the DON, on 02/10/13

F 520 the Medical Director by the Administrator on a monthly basis, beginning the week of 3/24/13, to evaluate the effectiveness of new systems, policies and audit results. In conjunction with the Medical Director, the Administrator will work with department directors to implement any necessary system changes.

7) The DON, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director, Marketing and Admissions Director, Dietitian, Medical Director, and the Facility Rehab Coordinator will participate in a quarterly QA meeting which will be led by the Administrator to evaluate systems and their effectiveness which will include, but not limited to the following: QA will be conducted by the DON, beginning the week of 3/4/13 on 5 residents a week for 12 weeks to ensure all catheter tubing is secured and not touching the floor. If patterns and or trends are noted, systems will immediately be analyzed and any necessary changes implemented. Staff will be in-serviced on the changes and then be monitored for their effectiveness.

8) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

Alleged Date of Compliance

3/24/2013

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F 520 Continued From page 61
at 12:45 PM, revealed she had attended infection control seminars but was not a certified infection control nurse. She stated she had access to the infection control manual and online resources but had not received formal training on using the corporate infection control software or auditing tools. During continued interview, the DON provided evidence of infection control inservices, but acknowledged there had been no followup audits to ensure the training was effective.

Interview with the Administrator, on 02/10/13 at 2:15 PM, revealed he started at the facility in October 2012 and there had been only one (1) QA meeting since his arrival. He stated he was aware there was a high rate of infection, based on the numbers he heard at the QA meeting in November 2012. He further stated he assumed tracking and trending was being done, but realized now it had not been carried far enough. Continued interview revealed the administrator know there was some monitoring occurring, but he did not know exactly how the data was collected and recorded. The administrator acknowledged the QA process had not been carried through as it related to the facility's infection rate. He stated he should have known more but just had not been with the facility long enough.

F 520 1.5 LPN #10 was immediately educated by Clinical Coordinator on 2/7/2013, related cleansing of gluco-meter, washing hands and infection control. The lancets, gluco-meter strips and basket were immediately discarded on 2/7/2013 and not used.

- 1) No residents showed ill effects from the alleged deficient practice as evidenced by no new infections.
- 2) RNs and LPNs were in-serviced by DON on 3/1/2013 and 3/4/2013 related to cleansing of gluco-meter, washing hands and infection control.
- 3) A weekly meeting will be held beginning the week of 3/24/13 with the Administrator, DON/designee, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director and Marketing and Admissions Director. The weekly meeting will review the prior week's audit results. During the meeting, department directors will be evaluating systems, policy compliance and effectiveness. As issues and or trends are identified, a root cause analysis will be conducted, and if necessary, new measures and system changes will immediately be implemented which will include, but not limited to staff training and then monitored for effectiveness. Results of the audits will be presented to the Medical Director by the Administrator on a monthly basis,

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F 520 Continued From page 61
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Interview with the Administrator, on 02/10/13 at 2:15 PM, revealed he started at the facility in October 2012 and there had been only one (1) QA meeting since his arrival. He stated he was aware there was a high rate of infection, based on the numbers he heard at the QA meeting in November 2012. Her further stated he assumed tracking and trending was being done, but realized now it had not been carried far enough. Continued interview revealed the administrator know there was some monitoring occurring, but he did not know exactly how the data was collected and recorded. The administrator acknowledged the QA process had not been carried through as it related to the facility's infection rate. He stated he should have known more but just had not been with the facility long enough.

F 520 beginning the week of 3/24/13, to evaluate the effectiveness of new systems, policies and audit results. In conjunction with the Medical Director, the Administrator will work with department directors to implement any necessary system changes.

4) The DON, Director of Environmental Services, Dietary Director, Social Services Director, Activities Director, Marketing and Admissions Director, Dietitian, Medical Director, and the Facility Rehab Coordinator will participate in a quarterly QA meeting which will be led by the Administrator to evaluate systems and their effectiveness which will include, but not limited to the following: QA will be conducted by DON/designee, beginning the week of 3/4/13 monitoring 5 employees a week for 12 weeks to ensure proper gluco-meter cleansing, hand washing and infection control. If patterns and or trends are noted, systems will immediately be analyzed and any necessary changes implemented. Staff will be in-serviced on the changes and then be monitored for their effectiveness.

5) The Administrator will ensure compliance through review and evaluation of the effectiveness of the implemented system changes and Quality Assurance studies.

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			Alleged Date of Compliance	3/24/2013	

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 Edition)

Facility type: SNF/NF

Type of structure: Type V (000)

Smoke Compartment: Nine (9)

Fire Alarm: Fire alarm with single station smokes in resident rooms

Sprinkler System: Complete sprinkler system (wet and dry)

Generator: Type II, Diesel installed 1999

A standard Life Safety Code survey was conducted on 02/05/13. Florence Park Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred thirty-six (136). The facility is licensed for one hundred fifty (150).

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or

K 000

This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Florence Park Care and Rehabilitation facility agrees with the citations noted on the pages of this Statement of Deficiencies. Florence Park Care and Rehabilitation facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.

K-018

Florence Park Care and Rehabilitation Facility makes every effort to ensure that facility corridor doors would resist the passage of smoke.

1. Resident rooms 115, 116, 200 and 315 were inspected by Maintenance Director and repaired 2/27/13 by adjusting hinges, latches and catch plates to ensure proper latching.
2. The Director of Maintenance inspected the facility resident rooms 2/27/13 to identify other rooms that would not latch properly. No other rooms were identified.
3. The Director of Maintenance or designee will perform a follow-up inspection of resident rooms in three months, then annually to ensure that facility resident rooms latch properly. Resident rooms that do not latch properly will be repaired immediately and findings will be presented during the Quarterly Quality Assurance meeting.
4. Completion Date

2/27/2013

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

David [Signature]

TITLE

Administrator

(X6) DATE

3-4-13

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

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K 018 Continued From page 1

K 018

hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is ~~no impediment to the closing of the doors.~~ Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure corridor doors would resist the passage of smoke. The deficiency had the potential to affect three (3) smoke compartment, eight (8) residents, staff, and visitors.

The findings include:

Observation on 02/05/13, between 9:30 AM and 3:00 PM, revealed resident room doors 115, 116, 200, and 315 would not latch when shut. Resident room doors must latch to resist the passage of smoke. The observation was confirmed with the Regional Maintenance

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K 018 Continued From page 2
Director.

K 018

Interview on 02/05/13, at 1:00 PM, with the Maintenance Director, revealed he was not aware the resident room doors, located in the corridor, would not latch. This was confirmed with the Administrator and Director of Nursing at exit conference.

Reference: NFPA 101 (2000 Edition).

19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.
Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS-F

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each

K-025

Florence Park Care and Rehabilitation Facility works diligently to ensure that smoke barriers are maintained according to National Fire Protection Association (NFPA) standards.

1. Areas identified in the smoke compartment barriers that had penetrations not sealed around where conduit penetrated the walls will be properly sealed per NFPA standards by the Director of Maintenance, by 3/8/13.

The blocks identified to have missing grout will also be repaired by 3/8/13.

2. The facility was re-inspected by the Director of Maintenance 2/26/13 to ensure that other areas in the building were free from barrier penetrations. No other areas were identified.

3. Facility Director of Maintenance will perform on-going follow-up inspections following work performed in the areas of the building that would affect the smoke barriers to ensure that no penetrations exist. Any areas identified will be immediately documented and repaired. Inspection of

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K 025 - Continued From page 3
floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025 facility smoke barriers will occur no later than six months on an ongoing basis. Penetrations identified will be documented and immediately repaired. Penetration areas documented will be presented to the Quarterly Quality Assurance Meeting for review.

4. Completion Date

3/8/2013

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, one hundred thirty-six (136) residents, staff and visitors. The facility is licensed for one hundred fifty (150) beds and the census was one hundred thirty-six (136) the day of the survey.

The findings include:

Observation, on 02/05/13 between 9:30 AM and 3:00 PM, revealed all nine (9) smoke barriers had penetrations not sealed around where conduit penetrated the walls also noted the grout was missing in about 2-3 blocks. Smoke barriers are to be sealed with a material that is equal or greater than existing material or fire rated. Penetrations in smoke barriers must be sealed to prevent the spread of smoke during a fire. The observations were confirmed with the Maintenance Director. This was also confirmed with the Administrator and Director of Nursing at exit conference.

Interview, on 02/05/13 at 1:40 PM in the main Hallway, with the Maintenance Director revealed

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K 025 Continued From page 4
he had some work to complete.

K 025

Reference: NFPA 101 (2000 edition)
8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:
(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:
a. It shall be filled with a material that is capable of limiting the transfer of smoke.
b. It shall be protected by an approved device that is designed for the specific purpose.
(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:
a. It shall be filled with a material that is capable of limiting the transfer of smoke.
b. It shall be protected by an approved device that is designed for the specific purpose.
(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:
a. It shall be made on either side of the smoke

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K 025 Continued From page 5

partitions.
b. It shall be made by an approved device that is designed for the specific purpose.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that hazardous areas were maintained as required. This deficient practices affected two (2) of nine (9) smoke compartments, staff, and approximately twenty-four (24) residents. The facility is licensed for one hundred fifty (150) beds with a census of one hundred thirty-six (136) on the day of the survey.

The findings include:

During the Life Safety Code survey on 02/05/13 between 9:30 AM and 3:00 PM, with the Director of Maintenance, observation revealed a soiled utility room located in the main rehab hall had a

K 025

K 029 K-029

Florence Park Care and Rehabilitation Facility strives to ensure that hazardous areas are maintained.

1. The penetration around the metal pipe in the soiled utility room located on the Rehab. Hall will be properly sealed by 3/8/13 by the Director of Maintenance / designee. The penetrations in the mechanical room will be properly sealed by 3/8/13 by the Director of maintenance / designee.

2. Other facility mechanical rooms and utility rooms were inspected for the presence of penetrations 2/26/13 by the Director of Maintenance. No other penetrations were identified.

3. The Facility Director of Maintenance will perform follow-up inspections in three

months to ensure that facility mechanical rooms and utility rooms remain free from penetrations. Any penetrations found during the follow-up inspections will be documented and repaired immediately. The findings will be reported to the Quarterly Quality Assurance Committee for review.

4. Completion Date

3/8/2013

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K 029 Continued From page 6
penetration around a metal pipe not sealed to prevent the spread of smoke as required by NFPA 101. Also the mechanical room had 10 penetrations not sealed to prevent the spread of smoke. The mechanical room consisted of electrical panels and three (3) gas hot water heaters.

K 029

Interview with the Maintenance Director on 02/05/13 at 11:50 AM revealed he was not aware of this requirement. This was also confirmed with the Administrator and the Director of Nursing at exit conference.

Reference: NFPA 101 (2000 Edition).

- 19.3.2.1 Hazardous Areas.
Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:
- (1) Boiler and fuel-fired heater rooms
 - (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
 - (3) Paint shops
 - (4) Repair shops
 - (5) Soiled linen rooms
 - (6) Trash collection rooms
 - (7) Rooms or spaces larger than 50 ft² (4.6 m²).

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K 029 Continued From page 7
including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction

K 029

(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K-038
Florence Park Care and Rehabilitation Facility makes every effort to ensure that delayed egress doors and exits are maintained in accordance with NFPA standards.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD SS=F
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 038
1. The three facility egress doors equipped with a keypad locking system had keypad codes posted 2/7/13 by the Director of Maintenance. Temporary signs for the nine (9) facility doors equipped with delayed egress were posted 3/1/13 by the Director of Maintenance. Permanent signs have been ordered from Accu-tex signs and banners 2/28/13 by the Director of Maintenance. Permanent signage was ordered by 3/8/14 by the Director of Maintenance / designee. The keypad for the wooden gate leading from Memory Care was disconnected 3/1/13 by the Director of Maintenance.

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for one hundred fifty (150) beds with a census of one hundred thirty-six (136) on the day of the survey.

2. The Director of Maintenance / designee will perform follow-up inspections quarterly to ensure that signs and codes remain in place. Signs and or codes in need of replacing will be documented and replaced immediately. Findings will be presented to the Quality Assurance meeting quarterly for review.

The findings include:

Completion Date

3/8/2013

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K 038 Continued From page 8
Observation, on 02/05/13 between 9:30 AM and 3:00 PM with the Maintenance Director, revealed three (3) egress doors were locked at the facility with the only way to exit was to enter a code. The code was not posted at the exits.

K 038

Interview, on 02/05/13 at 11:08 AM with the Maintenance Director revealed he was unaware the doors were required to have the code posted with the keypad to exit. This was also confirmed with the Administrator and the Director of Nursing at the exit conference.

Observation on 02/05/13 between 9:30 AM and 3:00 PM revealed nine (9) exit doors equipped with delayed egress devices, did not have proper signage stating Push until alarm sounds Door can be opened in 15 seconds, as required by NFPA 101. Also noted the wood gate in the exit discharge path of travel of memory care unit had a keypad locking device that would prevent the rapid removal of patients, staff and visitors in case of an emergency.

Interview on 02/05/13 at 11:15 AM, revealed he was not aware of the signage requirement.

Reference:

- NFPA 101 (2000 edition)
- 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic

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K 038 Continued From page 9
fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual

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means only.
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

K 038

(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS
NFPA 101 LIFE SAFETY CODE STANDARD

K 056
SS=F

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards.

K 056

K-056
Florence Park Care and Rehabilitation Facility diligently strives to ensure the building has a complete sprinkler system in accordance with NFPA Standards.
1. The materials needed to equip the three overhangs identified during the inspection were ordered from Genesis Fire Protection 2/27/13 by the Facility Maintenance Director.
2. Completion Date

2/27/2013

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K 056 Continued From page 11
The findings include:

K 056

Observation, on 02/05/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed three (3) overhangs that extended out four (4) foot or greater, (sixty-two (62) inches) made of combustible materials, and were not sprinkler protected. The overhangs were located outside the Long Term Care Hall, Memory Unit Long Hall, and Memory Care Men's Unit Hall

Interview, on 02/05/13 at 1:30 PM, outside with the Maintenance Director revealed he was not aware the overhang needed to be sprinkler protected. This was also confirmed during exit conference with the Director of Nursing and the Administrator.

Reference: NFPA 13 (1999 Edition) 5-13 8.1

Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD

SS=E

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was

K-062

Florence Park Care and Rehabilitation Facility strives to ensure that the facility sprinkler heads are maintained properly.
1. Sprinkler heads to replace the corroded sprinkler heads under the canopy outside on the loading dock, and H-pod exit canopy as well as well as the mixed sprinkler heads in the Activities room were ordered from Genesis Fire Protection 2/27/13 by the facility Director of Maintenance.

K 062

2. Facility sprinkler heads were inspected and 2/6/13 by the Director of Maintenance. No other heads were identified in need of replacement.
3. Follow-up inspection of sprinkler heads will occur semi-annually during the semi-annual fire inspections by the Director of Maintenance. Heads will be replaced as needed at this time. Findings will be reported to the Quality Assurance committee Quarterly for review.

Completion Date

2/27/2013

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K 062

determined the facility failed to ensure sprinkler heads were maintained as required. The facility is licensed for one hundred fifty (150) beds and the census on the day of the survey was one hundred thirty-six (136).

The findings include:

Observation during the Life Safety Code survey tour on 02/05/13, between 9:30 AM and 3:00 PM, with the Maintenance Director, revealed corrosion on two (2) sprinkler heads under canopy outside on the loading dock, and H-Pod exit canopy had two (2) corroded sprinkler heads. Not maintaining sprinkler heads can decrease their ability to react as intended.

Interview with the Maintenance Director on 02/05/13, at 2:25 PM, revealed he was not aware of the corroded heads being deficient and stated he thought the sprinkler company would have replaced the heads if needed.

Observation on 02/05/13 between 9:30 AM and 3:00 PM revealed four (4) mixed sprinkler heads in the Activities Room. Four quick response heads were identified mixed with regular response heads.

Interview with the Maintenance Director on 02/05/13 at 2:00 PM revealed he was not aware of this requirement but would contact the sprinkler contractor and have the correct sprinkler heads installed immediately.

Reference: NFPA 25 (1998 Edition).

2-2.1.1* Sprinklers shall be inspected from the

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K 062 Continued From page 13
 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

K 062

NFPA 101 2000 Edition
 19.3.5.3* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments and specifically references this paragraph, the sprinkler system shall meet the following criteria:
 (1) It shall be installed throughout the building in accordance with Section 9.7.
 (2) It shall be electrically connected to the fire alarm system.
 (3) It shall be fully supervised.
 (4) It shall be equipped with listed quick-response or listed residential sprinklers throughout all smoke compartments containing patient sleeping rooms.
 Exception No. 1: Standard response sprinklers shall be permitted to be continued to be used in existing approved sprinkler systems where quick-response and residential sprinklers were not listed for use in such
 Exception No. 2: Standard response sprinklers shall be permitted for use in hazardous areas protected in accordance with 19.3.2.1 locations at the time of installation.

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K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Means of egress are continuously maintained free of all obstructious or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect all smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred fifty (150) beds with a census of one hundred thirty-six (136) on the day of the survey.

The findings include:

Observation, on 02/05/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed medication carts were stored and not in use in corridors at nurses stations near room # 308, 212, and 108 at the nurses' stations. Broda chairs and electric chairs were also observed in corridor in the H-Pod hall corridor. Means of egress must remain clear of all obstructions and impediments at all times in case of emergency or fire.

Interview, on 02/05/13 at 1:10 PM, with the Maintenance Director revealed he was aware the facility routinely stored the medication carts in the

K 072 K-072

Florence Park Care and Rehabilitation Facility strives to maintain exit access in accordance with NFPA standards.

1. The corridors were cleared 2/6/2013 by facility staff and Director of Maintenance and placed in areas as to not obstruct exit access.
2. Facility staff were re-educated by Director of Maintenance 2/6/2013 with regards to the importance of storing carts when not in use out of corridors as to maintain exit access according to NFPA standards. The geri ctairs, broda chairs and motorized wheelchairs will be removed from the H-pod area 3/4/2013 by the Director of Maintenance / designee.
3. A quality assurance study will be conducted to ensure the clear access to exits by the Director of Maintenance / designee weekly x 4, then monthly x 3, then quarterly x 2. The findings will be recorded and reported to the Quality Assurance committee quarterly.
4. Date of Completion

3/4/2013

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corridors. K 072

Reference: NFFPA 101 (2000 Edition)
Means of Egress Reliability 7.1.10.1
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.