

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

OCT 17 2013

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION FACILITIES AND SERVICES A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2013
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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216
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F 000

INITIAL COMMENTS

A standard health survey was initiated on 09/17/13 and concluded on 09/19/13 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code Survey was conducted on 09/18/13 with deficiency cited at the highest scope and severity of a "D" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.

F 000

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.

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.

F 241

**F-241
S/S=Dignity**

I. Resident #7 the hospice notes were removed from the wall on 9/19/13 by RN Unit Manager to maintain and enhance their dignity. Audit Rounds were completed on 9/19/13 by the RN Nurse Unit Managers and determined there were no postings of hospice care notes in other resident rooms. On 9/18/13 Social Service Director updated behavior care plans for Resident #14 to reflect interventions for staff during meal services to promote dignity and safety. On 10/07/13 Social Service Director completed behavior audit to identify residents with behaviors. On 10/09/13 the RN Unit Manager updated nursing care plans with interventions to address resident behaviors to enhance their dignity. On 10/08/13 Social Service Director met with family of resident #14 updating new interventions for safety and dignity during meal service.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's Resident Rights, it was determined the facility failed to promote the care of residents in a manner to maintain and enhance the residents' dignity and respect for two (2) of twenty-two (22) sampled residents. Resident #7 and #14. The facility posted the Hospice careplan of Resident #7 on the wall of the bedroom and the staff segregated Resident #14 in the dining room and then failed to address the resident when the resident requested multiple times to get in the wheelchair.

continued next page

The findings include:

Review of the facility's Resident Rights given to residents and their family upon admission

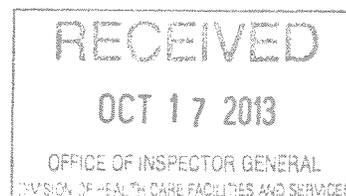
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Raymond Bell</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>10/17/13</i>
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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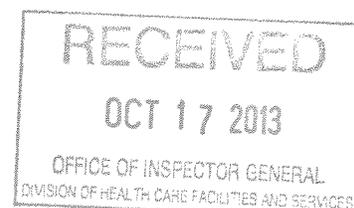
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F 241	<p>Continued From page 1</p> <p>revealed residents had the right to a dignified existence and self-determination and the right to be free of discrimination from the facility.</p> <p>Review of Resident #14's clinical record revealed the facility admitted the resident on 06/01/07 with diagnoses of Status Post Cerebrovascular Accident (CVA) with Hemiplegia (one sided weakness) and Impulse Control Disorder. Review of the Minimum Data Set (MDS), dated 03/12/13, revealed the facility assessed Resident #14 as needing supervision and cueing with eating as he/she would grab at other residents' food due to impulsivity. The MDS also indicated Resident #14 was interviewable as the facility assessed him/her with a cognition score of eight (8). Review of the MDS mood/behaviors category revealed Resident #14 had no maladaptive behaviors or moods. Review of a care conference report, dated 09/18/13, revealed Resident #14 would eat foods from the vending machine which were not on the resident's diet but the resident could be easily redirected. Review of the comprehensive care plan for Resident #14 revealed an approach to Resident #14 impulsively grabbing at other residents' food was to monitor the resident at mealtime and divert Resident #14 from other residents' food. Further review of the comprehensive care plan revealed in an evaluation note the residents' mother had been asked if the resident could be placed in a chair (out of his/her wheelchair) in the dining room at times to assist with keeping the resident from grabbing other residents' food. There was no indication on the care plan of where the chair would be placed in the dining room.</p> <p>Observation during the lunch meal, on 09/17/13 at 11:40 AM, revealed Resident #14 seated in a</p>	F 241	<p>II. On 9/19/13 the RN Unit Manager completed a facility audit of residents receiving hospice services for any hospice care plan posting and no other posting was identified. Social Service Director completed a behavior audit on 10/07/13. On 10/04/13 Social Service Director assessed resident and discussed behavior management plans with resident #22 and responsible party. On 10/08/13 assessed resident #14 and discussed behavior management plans with the resident and responsible party.</p> <p>III. On 9/19/13 the RN Unit Manager has contacted the hospice provider and re-educated hospice staff on not posting resident care plan notes in resident rooms. On 10/04/13 Staff Development Nurse and the Quality Assurance Nurse provided re-education to the nursing staff on monitoring resident rooms for hospice care notes not being posted in resident room.</p> <p>IV. The Director of Nursing, Social Service Director and/or the Staff Development Nurse will complete audits of hospice resident rooms for care notes postings and update resident care plan with intervention if a behavior is identified weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	<p>40/9/2013 10-10-13 per R. Bell by PB 10-18-13</p>



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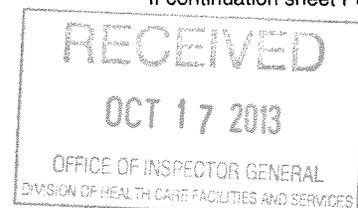
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F 241	<p>Continued From page 2</p> <p>dining chair in the dining room with the chair back against a wall and an overbed table over the resident's legs. Observation revealed thirty-six (36) other residents in the dining room at that time and all were seated in dining chairs at tables which sat four (4).</p> <p>Interview with Resident #14, on 09/17/13 at 11:45 AM, revealed he/she was seated in the chair against the wall and away from the other residents because "they put me here" and explained they were the staff. Resident #14 also stated he/she would rather sit at a table with other residents.</p> <p>Interview with the Speech Therapist, on 09/18/13 at 2:30 PM, revealed she had not been involved in the plan to place Resident #14 in a chair away from the other residents in the dining room, but she did think the resident appeared to be isolated from the other residents.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/17/13 at 11:50 AM, revealed Resident #14 was seated in a chair at the wall because the resident grabbed food from other residents' trays and had been seated like that for about six (6) months. She stated she knew that was the way Resident #14 should be seated in the dining room by word of mouth from other CNA's and not from the CNA care plan.</p> <p>Observation of the dining room, on 09/17/13 at 5:00 PM, during the supper meal revealed Resident #14 seated in the dining chair against the wall with an overbed table across the legs.</p> <p>Interview with CNA #2, on 09/17/13 at 5:05 PM, revealed Resident #14 had been seated in the</p>	F 241		



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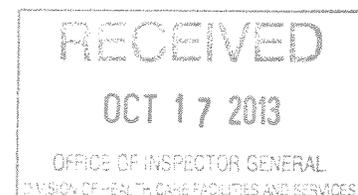
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F 241	<p>Continued From page 3</p> <p>dining chair in the dining room for at least eight (8) months and it was done to keep Resident #14 from grabbing other residents' food. She stated Resident #14 could self-propel the wheelchair, but could not stand up out of the dining chair. She indicated Resident #14 could move the overbed table away from his/her legs. She further stated she had not heard Resident #14 say he/she did not like sitting away from the other residents.</p> <p>Observation, on 09/18/13 at 6:48 AM, revealed Resident #14 self-propelled his/her wheelchair in the hallway outside of the dining room and at 6:53 AM self-propelled wheelchair into the dining room and stopped in front of the television to watch the news. Further observation of the dining room, on 09/18/13 at 6:58 AM, revealed CNA #5 take hold of Resident #14's wheelchair handles, push the wheelchair to the dining chair at the wall and transfer Resident #14 to the dining chair.</p> <p>Continued observation, on 09/18/13 during the breakfast meal in the main dining room at 7:30 AM, revealed Resident #14 asked for help to get back in his/her wheelchair to leave the dining room. There was a Certified Nursing Assistant (CNA) at a table in close proximity to Resident #14, CNA #3, who was to assist the residents and CNA #3 responded she would assist Resident #14 when she finished assisting to feed the resident she was attending.</p> <p>Continued observation at 7:35 AM, revealed two (2) additional CNAs entered the dining room. They were not asked by CNA #3 to assist Resident #14. CNA #3 was then observed to move her chair next to another resident who needed assistance to be fed and CNA #3 did not</p>	F 241			



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F 241	Continued From page 4 attend to Resident #14. Resident #14 continued to request someone to "please help me". At 7:40 AM, five (5) CNAs were present, CNA #3, 4, 5, 6 and 7 and no one assisted Resident #14. Resident #14 was again heard to call out "Please help me". At 7:42 AM, CNA #4 sat down to assist a resident to eat. At 7:45 AM, CNA #7 removed a resident from the dining room via wheelchair. Resident #14 was heard to say "Will you please, please help me to my chair". No one was observed responding to Resident #14 either physically or verbally. At 7:50 AM, Resident #14, in a louder voice than had previously been heard, called out "Will you please help me?" No one present in the dining room was observed responding to Resident #14. At 7:53 AM, a resident sitting at a table with a walker by their side, had asked if someone could take him/her back to his/her room. CNA #7 responded she could take the resident to his/her room and went over to the resident immediately and both the CNA and resident left the dining room. Resident #14 remained in the dining room calling out for help. At 7:54 AM, CNA #6 escorted another resident out of the dining room via wheelchair. Resident #14 called out "Please help me". At 7:57 AM, CNA #7 returned to the dining room and escorted another resident out of the dining room via wheelchair. At 7:58 AM, CNA #6 returned to the dining room. Resident #14 waved his/her hands while facing the direction of CNA #6 and said, in a loud voice, please help me, please, please, please. CNA #6 was seen stopping next to another resident, touching that resident on the shoulder, then approached Resident #14 and told Resident #14 she would help him/her. At 8:00 AM, CNA #6 and CNA #7 placed Resident #14 in his/her wheelchair, which was situated next to the chair the resident was sitting in, and Resident #14	F 241			



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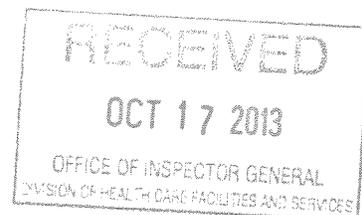
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F 241	<p>Continued From page 5</p> <p>was rolled to directly outside the dining room. Resident #14 had been calling out for help for thirty (30) minutes before he/she was assisted. Throughout the observation of the dining room, a licensed staff person was not monitoring the dining room.</p> <p>Interview, on 09/18/13 at 9:30 AM, with CNA #5 revealed she had heard Resident #14 call out for help. She revealed she did not respond to the resident because CNA #3 had said she would help the resident when she was finished assisting the resident she was feeding. However, CNA #5 revealed she saw CNA #3 continued on to assist another resident and not help Resident #14. CNA #5 herself offered no assistance to Resident #14 while Resident #14 continued to call out for help.</p> <p>Interview, on 09/18/13 at 9:36 AM, with CNA #7 revealed she did not hear Resident #14 call out for help. However, when seated on the opposite side of the dining room from Resident #14, this surveyor could hear the resident continually call out for help.</p> <p>Interview, on 09/18/13 at 9:47 AM, with CNA #3 revealed Resident #14 ate his/her meal really fast and as soon as the resident finished, he/she wanted to be put into the wheelchair. CNA #3 stated that was why she did not get up to help Resident #14. CNA #3 stated they don't leave the care of one resident to care for another. However, when CNA #3 had finished assisting the resident she was feeding, she physically moved her chair to start feeding another resident and not attending to Resident #14 as she had stated to</p>	F 241			



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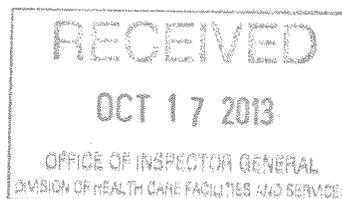
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F 241	<p>Continued From page 6</p> <p>Resident #14 she would do. CNA #3 stated she had told Resident #14 two (2) or three (3) times she would help him/her. She stated she did not help Resident #14 because she was feeding another resident.</p> <p>Interview, on 09/18/13 at 10:15 AM, with CNA #4 revealed she had not heard the multiple requests of Resident #14 to get out of the dining room chair and into his/her wheelchair. She stated she was not asked to assist Resident #14. CNA #4 revealed there was usually a nurse to oversee the dining room who would have assisted the resident.</p> <p>Interview with CNA #5, on 09/18/13 at 8:05 AM, revealed she was familiar with Resident #14 and she thought the resident had been seated, secluded from the other residents, for about a year due to the resident would grab other residents food. She indicated she had learned to place the resident there by word of mouth from the nurses and other CNAs.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP), on 09/18/13 at 11:19 AM, revealed if she saw Resident #14 seated in a dining chair against a wall with an overbed table over the legs during a mealtime she would wonder why he/she was the only resident seated like that.</p> <p>Interview with the Director of Nursing (DON), on 09/18/13 at 5:35 PM, revealed Resident #14 was kept isolated in the dining room to keep him/her safe although she indicated this was not documented in the residents record. She also indicated no other approaches had been instigated to keep Resident #14 from grabbing</p>	F 241		



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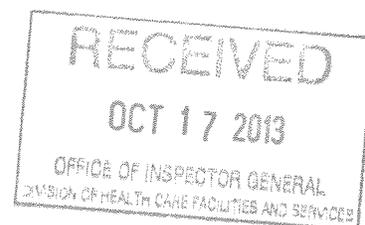
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F 241	<p>Continued From page 7</p> <p>other residents' food and she could see how the resident might appear to be isolated. She further stated no one had asked Resident #14 how he/she felt about sitting apart from the other residents in the dining room.</p> <p>Observation of Resident #7, on 09/17/13 at 8:25 AM and 4:50 PM, revealed a Hospice care plan, indicating the days of the week the resident received a bath/shower from the Hospice aide, taped to the wall above the headboard of the bed.</p> <p>Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Dementia, Failure to Thrive, Hypertension. The facility completed a Significant Change MDS, on 07/16/13, which revealed the resident was severely cognitively impaired, required limited to extensive assistance with activities of daily living and was incontinent of bowel and bladder. Hospice admitted the resident to their services on 09/07/13.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 09/17/13 at 1:50 PM, revealed Hospice always posted the care plan on the wall so facility staff would know when the Hospice aide was coming and what she would be doing. She stated she did not know the information was private.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 09/17/13 at 2:10 PM, revealed posting the bathing care plan was usual practice and did realize this was private information, however, since Hospice placed it on the wall, it must be all right. The LPN stated the care plan would be removed.</p> <p>Interview with the Director of Nursing, on</p>	F 241			



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<p>F 241</p> <p>F 279 SS=E</p>	<p>Continued From page 8</p> <p>09/19/13 at 4:10 PM, revealed she was not aware the care plan was posted over Resident #7's bed. She stated the care plan could not be posted as it violated the resident's right to privacy.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review of Care Plan Goals and Objectives, it was determined the facility failed to develop the comprehensive care plan for seven (7) out of twenty-two (22) sampled residents. The facility failed to develop care plans for Residents #1, #3, #9, #22, related to contact precautions</p>	<p>F 241</p> <p>F 279</p>	<p>F-279 S/S= E Care Plans</p> <p>I. Resident #1, #3, #9 and #22 care plans include contact precautions. Resident #7's care plan includes an interdisciplinary hospice plan of care. Resident #4 and #10 care plans address their behaviors.</p> <p>II. Residents have been assessed and residents requiring contact precautions, hospice services or exhibiting behaviors have had their care plans reviewed and revised where needed to address current care issues. On 10/07/13 the MDS Coordinator, Social Service Director and Quality Assurance Nurse completed an audit of residents to identify residents requiring contact precautions, hospice services or exhibiting behaviors. ON 10/07/13 the RN Unit Manager, MDS Coordinator and Social Service Director completed for those residents identified had their care plans reviewed and updated to address current care needs.</p> <p>III. On 10/09/13 the Quality Assurance Nurse and Staff Development Nurse have provided re-education for the nursing staff and interdisciplinary Care Plan Team regarding contact precautions, hospice and behaviors on the plan of care. The re-education addresses our updated infection control guidelines and updates per CDC recommendations, hospice care plans integrated with facility care plan goals and behavioral care plan interventions added to the point of care for certified nursing assistant.</p> <p>continued next page</p>	



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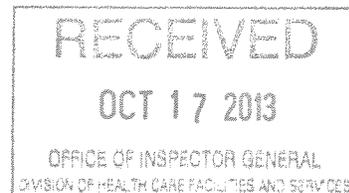
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2013
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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216
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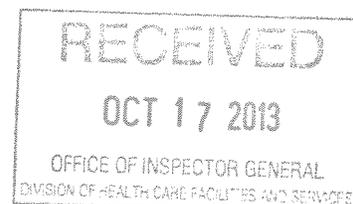
F 279	<p>Continued From page 9 and failed to develop care plans for Resident #7's Hospice care and Resident #4 and #10's behaviors.</p> <p>The findings include:</p> <p>Review of the facility's policy provided as the Care Plan Policy, titled Care Plan Goals and Objectives, undated revealed the policy stated care plan goals and objectives were defined as the desired outcome for a specific resident problem.</p> <p>1. Review of the clinical record for Resident #1 revealed the facility originally admitted the resident on 08/08/08 and readmitted on 04/24/12 with diagnoses of Ischemic Heart Disease, Hemiplegia, Hypertension, Pain, Urinary Tract Infection, Conversion Disorder and Dementia. The facility determined Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS) on 08/15/13 as part of the Minimum Data Set (MDS) Quarterly assessment to determine cognitive impairment. Resident #1 was diagnosed with a Urinary Tract Infection on 09/12/13 and started on antibiotics on 09/13/13. Extended-Spectrum Beta-Lactamases (ESBL) was confirmed in the urine of Resident #1 on the same date. The care plan included the antibiotic; however, no care plan was developed for the isolation precautions required for the contagious infection ESBL which spreads through contact with an infected patient, object, or surface.</p> <p>Observation, on 09/17/13 during the tour of the facility which began at 8:10 AM, of Resident #1's room revealed no isolation cart by the door and no signage on the door to indicate contact precautions were to be in used.</p>	F 279	<p>IV. The Director of Nursing, MDS/Care Plan Coordinator and/or Staff Development Coordinator will complete audits of care plans for residents on contact precautions, hospice and receiving behavior management plans weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	<p>10/9/2013 <i>JD-10-13</i> <i>per R. Bull</i> <i>by PB</i> <i>10-18-13</i></p>
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F 279	Continued From page 10 Observation, on 09/17/13 at 4:55 PM, revealed continued lack of notification for contact precautions for the room of Resident #1. In addition, Certified Nursing Assistant (CNA) #19 was observed going in the room of Resident #1 to do cares, did not glove or gown, touched the bed of the resident and assisted Resident #1 with a pillow for his/her neck. Interview, on 09/19/13 at 5:10 PM, with the South Nursing Supervisor revealed there was not a care plan developed for Resident #1 related to contact precautions and the C-diff diagnosis because it was not identified in the facility until 09/18/13 that contact precautions were to be in place for the resident. 2. Review of the clinical record for Resident #22 revealed the facility originally admitted the resident on 07/01/13 and readmitted on 09/04/13 from the hospital with diagnoses of Chronic Kidney Disease, Chronic Airway, Congestive Heart Failure and Clostridium Difficile (C-diff). A comprehensive care plan was not developed to include the C-diff or the need for contact isolation for Resident #22. In addition, Resident #22 was not in an isolation room upon readmit from the hospital. Observation, on 09/19/13 at 5:07 PM, revealed Resident #22 sitting in his/her room in a wheelchair visiting with a family member. The family member wore no gown or gloves and was sitting on the bed of the resident. An isolation cart was outside the resident's room. Interview, on 09/18/13 at 3:50 PM, with the Staff Development Coordinator revealed she	F 279		



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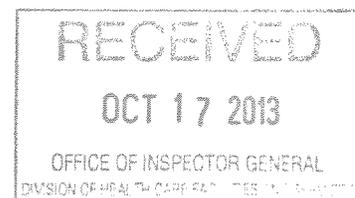
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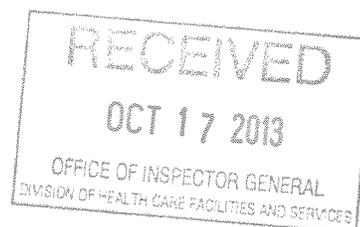
F 279	<p>Continued From page 11</p> <p>understood Universal Precautions and Contact Precautions to both mean the same thing. She revealed she would instruct all nurses that came in contact with ESBL or Clostridium difficile (C-diff) to use standard precautions which she defined as washing hands and wearing gloves.</p> <p>Interview, on 09/19/13 at 5:10 PM, with the South Nursing Supervisor revealed there was not a care plan developed for Resident #1 related to contact precautions and the C-diff diagnosis because it was not identified in the facility until 09/18/13 that contact precautions were to be in place for the resident.</p> <p>Interview, on 09/19/13 at 5:32 PM, with the Minimum Data Set (MDS) Coordinator revealed she did not know isolation was called for with residents with ESBL so it was not on the care plan of residents with ESBL.</p> <p>3. Review of the facility's policy for Behavior Management Program, undated, revealed the facility must ensure that a resident who displays mental or psychosocial adjustment difficulties receives appropriate treatment and services based on the comprehensive assessment.</p> <p>Review of a Recommendation, dated July 2013, and provided by the facility, revealed it was recommended that the facility use the Minimum Data Set as a guideline for behavior management. The document did not provide information regarding developing a care plan or management interventions for residents with</p>	F 279		
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F 279	<p>Continued From page 12 behaviors.</p> <p>Observation of Resident #4, on 09/17/13 at 11:00 AM and on 09/18/13 at 7:52 AM, revealed the resident sitting up in a wheelchair. The resident's hair was long and the resident had heavy facial hair, especially long around the upper and lower lips.</p> <p>Interview with Resident #4, on 09/17/13 at 4:30 PM, revealed the resident did not want to be interviewed.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Cerebral Vascular Accident, Anxiety and Depression. The facility completed a Quarterly Minimum Data Set (MDS) assessment, on 09/05/13, which revealed the resident required extensive assistance with all daily living tasks and was incontinent of bowel and bladder. The resident received an antidepressant and was cognitively intact; however, periods of confusion were noted.</p> <p>Review of the comprehensive care plan, dated 08/06/13, for Resident #4, revealed the resident had behaviors of verbal abuse toward staff, making negative statements about self, yelling out and refusal of care. Interventions included encouraging the resident to make decisions regarding a daily routine and care to decrease frustration. There was no documented evidence provided that showed the facility had planned care with the resident to determine the resident's preferences and a care plan developed based on those preferences. In addition, there was no documented evidence located to show how the facility developed a care plan to address the</p>	F 279		



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F 279 Continued From page 13
specific behaviors of making negative statements about self or yelling out.

Interview with Licensed Practical Nurse (LPN) #9, on 09/18/13 at 2:45 PM, revealed Resident #4 did refuse and resist care frequently. She stated the resident also balled up a fist and threatened to hit staff during care. She stated the resident sometimes did not get personal care timely due to these refusals.

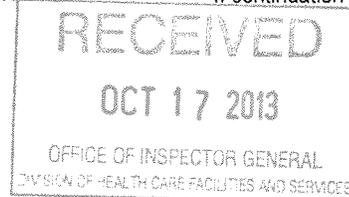
Interview with the MDS Nurse, on 09/18/13 at 1:15 PM, revealed a care plan was developed for each resident to address problems and provide interventions to manage the problems. She stated each behavior was not addressed specifically, but they were all together. She stated the resident was not consulted regarding care preferences.

4. Observation of Resident #10, on 09/17/13 at 11:45 AM and on 09/18/13 at 8:30 AM, revealed the resident was up in a wheelchair with long hair and unshaved.

Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Anoxic Brain Damage, Severe Social Conduct Disorder, Dysphagia and Diabetes. The facility completed a Quarterly Minimum Data Set (MDS) assessment on 08/22/13 which revealed the resident was severely cognitively impaired and required extensive assistance with daily living tasks. The resident was incontinent of bowel and bladder. The resident had received psychiatric care in the past; however, the last visit occurred in 02/2013.

Review of the comprehensive care plan, dated

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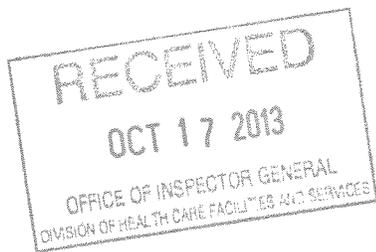
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F 279	<p>Continued From page 14</p> <p>08/23/13, for Resident #10, revealed the resident had behaviors of resisting/refusing care, verbal and physical abuse toward staff, sexual inappropriateness with staff, and non-compliance with thickened liquids. The goal established by the facility was to meet the residents needs. There were general interventions such as allowing the resident to vent his feelings and explain procedures before initiating, however, there was no documented evidence to show the facility had developed a care plan to address each behavior with specific interventions.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 09/18/13 at 2:10 PM, revealed Resident #10 would often get angry and hit and/or yell at nursing staff when they attempted to provide grooming and hygiene care. She stated the resident was sexually inappropriate at times and would refuse to have adult briefs changed when soiled. She stated she would leave the resident and try again another day. She stated she had received some training on dealing with combative residents, but the resident was much more difficult than other residents. She stated she was not aware of anything else to do with the resident when behaviors occurred.</p> <p>Interview with the Social Services Worker, on 09/18/13 at 2:20 PM, revealed Resident #10 did have behaviors and refused care. She stated this problem was on the care plan. She was not able to locate evidence of specific interventions for each behavior to guide staff in managing that behavior. She stated she did not know what could be done with the resident related to behaviors.</p> <p>Interview with the MDS Nurse, on 09/18/13 at</p>	F 279		
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F 279 Continued From page 15
1:15 PM, revealed a care plan was developed for each resident to address problems and provide interventions to manage the problems. She stated each behavior was not addressed specifically, but they were all together.

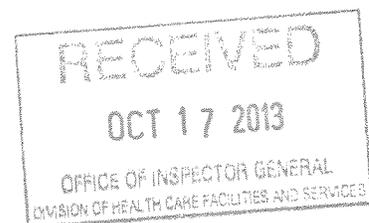
Interview with the Director of Nursing, on 09/19/13 at 4:10 PM, revealed the nurse or the MDS nurse could address a residents' care plan. She stated based on the issues Resident #10 had, the MDS nurse should have addressed each behavior.

5. Observation of Resident #7, on 09/17/13 at 11:15 AM, revealed the resident sitting up in a wheelchair in the common area holding a doll.

Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Dementia, Failure to Thrive, Hypertension. The facility completed a Significant Change MDS, on 07/16/13, which revealed the resident was severely cognitively impaired, required limited to extensive assistance with activities of daily living and was incontinent of bowel and bladder. The diagnosis of Protein-Calorie Malnutrition was added and the family determined the resident would not receive tube feedings and would be a Do Not Resuscitate on 09/05/13. An order was received from the attending physician for Hospice and the resident was admitted to Hospice on 09/07/13.

Review of the Hospice notes/care plan from 09/11/13, revealed the resident and family would receive crisis intervention, increase education regarding disease process, disease progression and medications, symptom relief, spiritual assistance, enhancement of spiritual well-being,

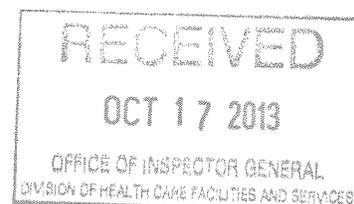
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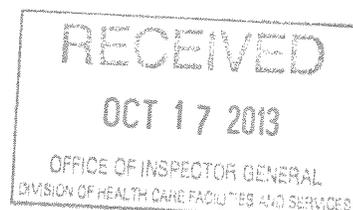
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F 279	<p>Continued From page 16</p> <p>pastoral counseling, activities of daily living care and other services.</p> <p>Review of the comprehensive care plan, dated 09/06/13, for Resident #7, revealed Hospice would be notified of changes in the resident's condition and would provide volunteers for the resident as needed. In addition, the facility would involve Hospice with care planning as indicated. There was no other evidence located to indicate the facility developed a care plan to address terminal care and the roles of Hospice and the facility.</p> <p>Interview with the Director of Nursing, on 09/19/13 at 4:10 PM, revealed a care plan should have been developed to address the addition of Hospice to the resident's care.</p> <p>6. Review of the clinical record for Resident #3 revealed the facility originally admitted the resident on 08/30/2013 with diagnoses of Cellulitis/Leg Abscess; Stage II Pressure Ulcers (multiple sites), Muscle Weakness; Morbid Obesity; Congestive Heart Failure (CHF); Lymphedema; Hypertension; Esophageal Reflux; and Rhabdomyolysis. On 09/11/13, it was confirmed that Resident #3 had Clostridium Difficile (C-Diff) of the bowel and he/she was being treated with an antibiotic (Flagyl), with scheduled completion of this course of treatment on 09/25/13. Review of the care plan for antibiotic therapy for C-Diff revealed there was no care plan for contact isolation precautions. Observation, on 09/17/13 at 8:30 AM, on initial tour of the facility revealed no isolation cart at the entry to Resident #3's room, and no indication on the door that contact precautions were to be in</p>	F 279		



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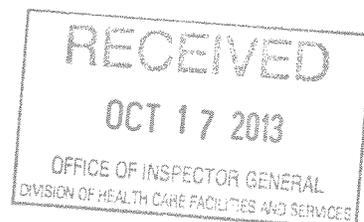
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F 279	<p>Continued From page 17 used.</p> <p>Observation, on 09/17/13 at 12:40 PM, revealed a CNA leaving Resident #3's room without washing her hands after delivering and setting up the resident's meal tray on an over-bed table.</p> <p>Observation, on 09/17/13 at 3:25 PM, revealed continued lack of contact precautions in the room of Resident #3.</p> <p>Observation, on 09/18/13 at 10:00 AM, revealed continued lack of isolation for contact precautions for the room of Resident #3. In addition, Licensed Practical Nurse (LPN) #3 was observed performing wound care and a skin assessment for Resident #3, but she was not wearing a disposable gown during the procedure. LPN #3's uniform came in contact with the resident's bed linens multiple times during wound care procedures.</p> <p>Interview, on 09/19/13 at 3:40 PM, with the Unit Manager for the South Unit, revealed there was not a care plan in place for contact precautions for Resident #3 because until the evening of 09/18/13, standard precautions were observed when caring for residents with C-Diff, not contact isolation. The Unit Manager stated now that it has been decided by the facility, to implement contact precautions, Resident #3 should have a care plan for C-Diff that included the use of contact isolation.</p> <p>7. Review of the clinical record for Resident #9 revealed the facility originally admitted the resident on 04/24/13 with diagnoses of Contusion of the Abdominal Wall with Hematoma; History of Urinary Tract Infections (UTIs); Chronic Myeloid</p>	F 279			



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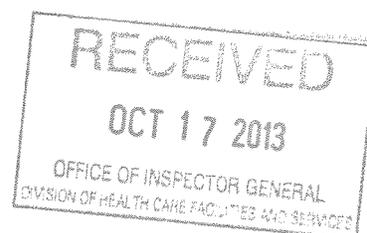
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F 279	<p>Continued From page 18</p> <p>Leukemia; Muscle Weakness; Hypertension; and a history of Shoulder Joint Replacement. The record further revealed on 09/11/13, it was determined Resident #9 had a confirmed case of ESBL of the urine, and was being treated with antibiotic therapy (Macrobid 100 mg, twice daily).</p> <p>Observation, on 09/17/13 at 8:30 AM during the initial tour of the facility revealed no isolation cart at the entry to Resident #9's room, and no indication on the door that contact precautions were to be in used.</p> <p>Observation, on 09/18/13 at 2:00 PM, revealed no isolation cart at the entry of Resident #9's room, and no indication on the door that contact precautions were to be in used.</p> <p>Observation, on 09/18/13 at 2:05 PM, revealed Resident #9 was seated in a wheel chair across the hallway from the South Unit's nurses' station. A male visitor was talking with Resident #9 while he/she sat with other residents.</p> <p>Interview, on 09/19/13 at 3:40 PM with the Unit Manager for the South Unit, revealed there was not a care plan in place for contact precautions for Resident #9 because until the evening of 09/18/13, standard precautions were observed when caring for residents with ESBL, not contact isolation. The Unit Manager stated now that it had been decided by the facility to implement contact precautions, Resident #9 should have a care plan for ESBL of the urine that included the use of contact isolation.</p>	F 279	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	see next page



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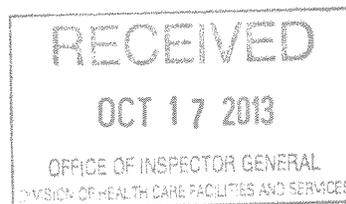
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F 371	<p>Continued From page 19</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure meals were served in a sanitary manner to three (3) of twenty-two (22) sampled residents and five (5) Unsampled Residents (Residents C, D and E) in the dining room on 09/17/13. Certified Nurse Aide (CNA) #9, with long hair, leaned over the table to talk to Unsampled Resident C while setting up the meal and the CNA's hair fell into the resident's meal tray. CNA #10 touched Unsampled Resident D's bread with their bare hands. CNA #11 repositioned a resident's wheelchair and locked the brakes then proceeded to serve Resident E without washing her hands. In addition, CNA #12 served a meal tray to a resident then removed the tray from the room and returned it to the meal cart containing unserved trays.</p> <p>The findings include:</p> <p>Review of the facility's policy, undated, for Serving Meals, revealed nursing staff were to assist residents with activities of daily living as needed. There was no information in the policy addressing Infection Control Practices.</p>	F 371	<p>F-371</p> <p>S/S=E Dietary Sanitation</p> <p>I. CNA #9's hair is being contained during meal service. CNA #9 replaced the meal tray. CNA #10 is using gloves when directly handling a food item. CNA #10 replaced the slice of bread. CNA #11 is utilizing hand-hygiene practices during meal service. CNA #12 is returning meal trays to the cart after meal trays are served.</p> <p>II. Staff with long hair is using hair restraints during meal service, gloves when directly handling a food item, completing hand-hygiene during meal service and returning meal trays to the carts after meal trays are served.</p> <p>III. On 9/17/13 the Quality Assurance Nurse and Staff Development Nurse have provided re-education to the staff regarding infection control/sanitation requirements during meal service. The re-education addresses staff with long hair using hair restraints during meal service, gloves when directly handling a food item, completing hand-hygiene during meal service and returning meal tray to the carts after meal trays are served. The nurses were re-educated on 9/17/13 on observing meal service and notifying Unit Manager(s) of the results.</p> <p>IV. The Director of Nursing, Staff Development Nurse, Dietary Manager and Unit Managers will complete audits of the dining room and tray service for meals weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	10/9/2013



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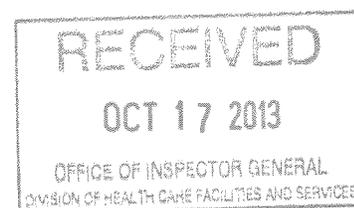
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/19/2013
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F 371	Continued From page 20 Observation of Unsampled Resident C in the dining room, on 09/17/13 at 11:43 AM, revealed the resident sitting at a table with CNA #9 removing food from a tray and setting up the meal. The CNA leaned over to talk with the resident and his long hair fell into the tray containing food items not yet served. Interview with CNA #9, on 09/17/13 at 11:45 AM, revealed he realized his hair had fallen over his shoulder; however, he did not realize it fell into the resident's tray. He stated it was an infection control violation and his hair could have germs and contaminate the food items left on the tray. Observation of Unsampled Resident D in the dining room, on 09/17/13 at 11:50 AM, revealed CNA #10 served the resident's meal. The resident asked for butter and the CNA moved the resident's bread aside to look for butter using her bare hands. Interview with CNA #10, on 09/17/13 at 11:55 AM, revealed she had received training on Infection Control and knew she should not have touched the resident's food with her bare hands. She stated she could spread germs to the resident's food causing illness. Observation of Unsampled Resident E in the dining room, on 09/17/13 at 12:02 PM, revealed CNA #11 touched a resident and repositioned the resident's wheelchair and set the brakes. The CNA then removed a meal tray from the cart and served Unsampled Resident E without washing her hands. Interview with CNA #11, on 09/17/13 at 12:15 PM,	F 371			



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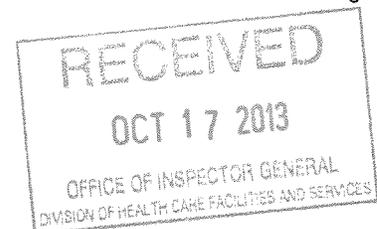
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F 371	<p>Continued From page 21</p> <p>revealed she should have washed her hands, however, she forgot. She stated she had been trained on Infection Control and knew failure to wash her hands could spread germs to residents making them sick.</p> <p>Observation of the meal tray service on the North Unit, on 09/17/13 at 12:15 PM, revealed CNA #12 delivered a meal tray to Room 121-B. The CNA sat the tray on the overbed table and pushed the table into position in front of the resident. The resident told the CNA that the meal was not wanted. The CNA picked the tray up and returned it to the meal cart with trays not yet served.</p> <p>Interview with CNA #12, on 09/17/13 at 1:50 PM, revealed she was not thinking when she returned the tray to the meal cart. She stated the tray was placed on the overbed table of the resident and was no longer clean. She stated she had received training on Infection Control.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 09/18/13 at 2:50 PM, revealed the nurses did supervise the dining room during meals and were supposed to monitor for Infection Control. The LPN stated the incidents were not seen; however, they could spread infection and make residents sick.</p> <p>Interview with the Director of Nursing, on 09/19/13 at 4:05 PM, revealed all nursing staff had received education on Infection Control and preventing the spread of bacteria to residents. She stated all the episodes placed the residents at risk of illness.</p>	F 371	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	see next page



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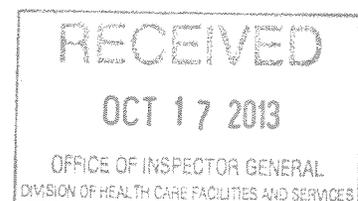
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F 441 SS=E	<p>Continued From page 22 SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F-441 S/S=E Infection Control</p> <p>I. Resident #1, #3, #9, and #12 are in contact precautions as recommended by the CDC. Resident #6's indwelling catheter tubing is positioned so not to touch the floor. Resident #3 is receiving their meal tray in a sanitary manner.</p> <p>II. Residents have been assessed for contact precautions and no other residents identified. On 9/20/13 Quality Assurance Nurse completed and audit of residents with active infections and indwelling catheters. On 9/20/13 Quality Assurance Nurse assessed residents with indwelling catheters and tubing is positioned not to touch the floor. Residents are being monitored by an assigned nurse in the dining room at meal service to receive meal trays in a sanitary manner.</p> <p>III. On 10/04/13 and 10/09/13 the Quality Assurance Nurse, Unit Manager and Staff Development Nurse re-educated facility staff on CDC guidelines for contact isolation requirements. On 10/04/13 the Staff Development Nurse with assistance from the Quality Assurance Nurse provided re-education on Infection Control practices to the facility staff with return demonstration on hand-hygiene and sanitary meal tray service. In addition, on 10/04/13 and 10/09/13 the Staff Development Nurse has completed return demonstration education for catheter positioning, food service hygiene, hair restraints, isolation guidelines, hand washing and donning/doffing gown/gloves with facility staff.</p> <p>continued next page</p>	



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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy reviews, it was determined the facility failed to maintain an Infection Control Program that provided a safe, sanitary, and comfortable environment for prevention of infections for five (5) of twenty-two (22) sampled residents, Residents #1, #3, #9, and #22 who had infections for which contact isolation was the acceptable standard of practice recommended by the Centers for Disease Control and Prevention (CDC). In addition, the staff allowed the indwelling catheter tubing and urine collection bag of Resident #6 to touch the floor, and a Certified Nursing Assistant (CNA) placed a meal tray on an over-bed table that also contained a urinal and did not sanitize her hands after moving the urinal and continuing to assist Resident #3 with his/her meal tray. The findings include: Review of the facility's Infection Control Program (Dated 04/17/2000), revealed there was an Infection Control Manual at each nurses station, and written isolation procedures existed and were to be adhered to correctly and appropriately. Interview, on 09/18/13 at 3:50 PM, with the Staff Development Coordinator revealed staff was instructed to use standard (contact) precautions when giving direct care to residents with C-Diff. During the interview, the Staff Development Coordinator stated contact and standard precautions were very much the same, with a little more attention to being careful when a resident was diagnosed with C-Diff or other highly	F 441	IV. The Director of Nursing, Unit Managers, RN supervisors and/or Staff Development Coordinator will complete infection control audits 3 times a week for 4 weeks, weekly for 4 weeks, monthly for 3 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. Completion Date:	40/9/2013 <i>10-10-13</i> <i>M.R. Bell</i> <i>DJPB</i> <i>10-18-13</i>	



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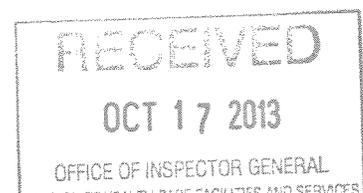
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contagious diseases.

Review of the Infection Control Manual at the South Unit's nurses' station, revealed a document within this manual from the Massachusetts Department of Public Health (Revision Date 04/1997) which provided guidelines for enteric precautions. This document recommended the use of gloves when caregivers came in contact with infected feces, proper hand washing, routine environmental decontamination, but disposable gown use was not mentioned.

Review of the Centers for Disease Control and Prevention (CDC) Guidance for Health Care Providers (Reviewed 11/25/2010, Updated 03/06/2012), revealed Contact Isolation Precautions were to be in place for known or suspected cases of Clostridium Difficile (C-Diff) infection. Private rooms were recommended. If not available, cohorting with other residents with known C-Diff was acceptable. Gloves and gown use was recommended while giving direct care and care givers were to wash their hands prior to exiting the patient's (resident's) rooms. Adequate cleaning/disinfection of environmental surfaces and reusable devices should occur using Environmental Protection Agency (EPA) registered disinfectants with a spermicidal claim. Generic sources of hypochlorite (e.g., household chlorine bleach) may be diluted and used.

Record review of the facility's reported infections for September 2013, revealed seven (7) resident infections had been identified to date. Two (2) of the residents had confirmed cases of C-Diff (Resident #3 and Resident #22). Two (2) residents had confirmed cases of ESBL (Resident #1 and Resident #9).

F 441



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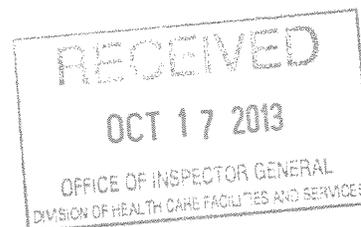
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F 441	<p>Continued From page 25</p> <p>Interview, on 09/19/13 at 10:10 AM, with the Unit Manager for the South Unit revealed the nursing staff implemented contact isolation precautions 09/18/13 at approximately 6:00 PM, for Residents #1, #3, #9, and #22, after being directed to do so by the DON. In order to prevent the spread of these infections, the Unit Manager stated it was important for care givers to consistently observe contact precautions which included use of PPE such as gowns and gloves, and to observe proper hand washing when caring for residents with diagnosed C-Diff and ESBL.</p> <p>1. Review of the clinical record for Resident #3 revealed he/she was diagnosed with C-Diff of the bowel on 09/11/13, and was receiving antibiotic therapy (Flagyl) until 09/25/13.</p> <p>Observation, on 09/17/13 at 8:30 AM, during initial tour of the facility did not reveal Personal Protective Equipment (PPE) was available at the entry ways of the rooms of Resident #3 and Resident #9. There were no receptacles available for PPE disposal upon exiting these rooms, and there was no signage posted at either doorway to alert visitors to see the nurse prior to entering the rooms.</p> <p>Observation, on 09/17/13 at 12:10 PM, revealed Resident #3 was being transported by staff via wheelchair from his/her room to the Physical Therapy Department. Approximately 10 minutes later, the therapist transported Resident #3 via wheelchair, back to his/her room.</p> <p>Observation, on 09/17/13 at 12:29 PM, during the lunch meal tray pass revealed the tray delivered to Resident #3 was placed on an over bed table</p>	F 441		

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F 441	<p>Continued From page 26</p> <p>next to a urinal by a Certified Nursing Assistant (CNA). The CNA then removed the urinal and slid the tray over in front of the resident. The table was not sanitized. The CNA did not wash her hands.</p> <p>Observation, on 09/18/13 at 1:05 PM, revealed Resident #3 in his/her room talking with a visitor who was seated by his/her bed. The visitor was not wearing a disposable gown or gloves.</p> <p>Interview, on 09/17/13 at 3:20 PM, with CNA #8 revealed she was informed by the unit's nurses that Resident #3 had tested positive for C-Diff, which was described to her as a virus in Resident #3's bowel movements. She stated she was instructed to maintain proper hand washing technique and to use gloves when caring for the resident. She was to make sure Resident #3's loose stools were contained, and soiled briefs were to be tied in plastic bags and were to be disposed of in the trash bin in the South Wing Shower Room. CNA #8 stated she had not seen a sign posted at Resident #3's door to alert visitors to see the nurse prior to entering the room, nor had she seen an isolation cart at the entry to Resident #3's room.</p> <p>Interview, on 09/17/13 at 3:35 PM, with Registered Nurse (RN) #1 revealed she was aware Resident #3 was being treated for C-Diff. RN #1 stated all direct care givers were informed of new or special care instructions for residents with infectious diseases at each shift change. Direct care givers were instructed to wash their hands and use gloves while performing care for the residents, but contact isolation had not been in effect for Resident #3. RN #1 stated Resident #3's visitors should see the nurse for instructions</p>	F 441		



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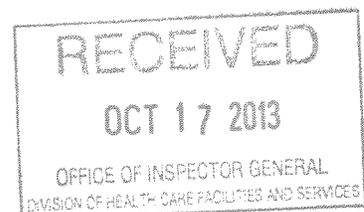
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F 441	<p>Continued From page 27</p> <p>prior to visiting, but signage had not been posted to advise visitors to see the nurse before visiting Resident #3. RN #1 further stated direct care staff or anyone entering Resident #3's room should wash their hands upon entering and leaving the room. Gloves should be worn while giving direct care to Resident #3.</p> <p>Observation, on 09/18/13 at 10:00 AM, revealed there was no isolation cart (PPE) in place outside Resident #3's room. Resident #3's skin assessment and wound care was performed by Licensed Practical Nurse (LPN) #3. LPN #3 did not wear a disposable gown, and her uniform (scrubs) came in direct contact with Resident #3's bed linens multiple times during the wound care procedures. In addition, LPN #3 was observed talking to the Resident #3 just prior to the skin assessment and while doing so, the nurse's arms rested directly on the foot board of the resident's bed. LPN #3 used a flashlight while she measured/assessed Resident #3's wounds and a pair of bandage scissors were used to cut away a wrapped gauze dressing before treating a wound on the resident's left foot. The LPN did not clean the equipment when finished with the treatment.</p> <p>Interview, on 09/18/13 at 10:55 AM with LPN # 3, revealed the scissors and the flashlight were not dedicated solely to the care of Resident #3, but she stated she cleaned these items with bleach wipes after using them.</p> <p>Observation, on 09/18/13, at 10:58 AM, revealed LPN #3 opened the unit's treatment cart positioned just outside Resident #3's room, but bleach wipes were not available for cleaning the scissors and the flashlight.</p>	F 441		
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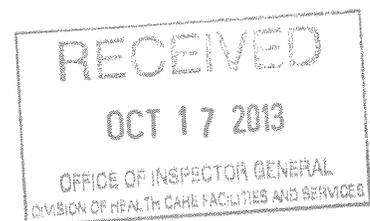
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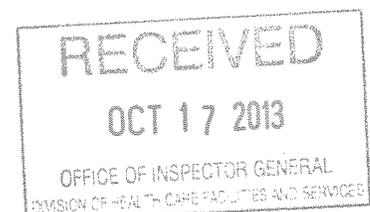
F 441	<p>Continued From page 28</p> <p>Interview, on 09/17/13 at 3:45 PM, with LPN #2 (2nd shift nurse supervisor), revealed Resident #3 was being treated with an antibiotic for C-Diff, but she stated the resident had not had loose stools since 09/16/13. LPN #2 stated the nursing staff informed the Unit's CNAs to use standard precautions when giving care to residents with C-Diff, which meant the use of hand washing before donning and after removing disposable gloves. In addition CNAs were instructed to tie up (seal) the resident's soiled briefs in plastic bags and dispose of them in a trash bin kept in the shower room.</p> <p>Observations of Resident #3, on 09/17/13 at 8:30 AM, 10:55 AM, 12:10 PM and 12:30 PM and observations of Resident #9 on 09/17/13 at 11:00 AM, 11:45 AM, and on 09/18/13 at 8:20 AM, 1:15 PM, and 2:05 PM, revealed neither Residents #3 or #9 had PPE stored at the entry ways of their rooms for use by care givers and visitors. Signs were not posted outside the doorways of their rooms to advise visitors to see the nurse before visiting these residents.</p> <p>Review of the clinical record revealed Resident #9 was diagnosed with ESBL on 09/11/13.</p> <p>Interview, on 09/19/13 at 10:50 AM, with the Interim DON revealed if the nursing staff had questions/concerns about how to manage residents with diagnosed infections such as C-Diff or ESBL, they should contact the DON or the Staff Development Coordinator who trained the staff in isolation procedures. The DON stated that on 09/18/13, the facility obtained newer CDC guidelines (dated 2007) for isolation precautions specific to C-Diff and ESBL, and contact isolation precautions were implemented during the</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/19/2013
NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
(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	<p>Continued From page 29</p> <p>evening of 09/18/13 for the residents with diagnosed C-Diff and ESBL. The DON stated universal/standard precautions were different from contact isolation precautions in that gowns should be a part of the utilized PPE. In addition, infected residents should be placed in private rooms if possible or co-horted with residents who have the same infections. The DON stated that all residents in the facility were vulnerable of the risk for acquiring C-Diff and ESBL when full contact isolation precautions were not in effect. In addition, the DON stated she and the Staff Development Coordinator were responsible for ensuring the content of the Infection Control in-services were accurate and up to date per acceptable standards of practice recommended by the CDC.</p> <p>2. Review of the policy for Indwelling Catheters, undated, revealed there was no documentation of infection prevention practices for residents with catheters.</p> <p>Observation of Resident #6, on 09/17/13 at 11:42 AM and 4:45 PM, revealed the facility had seated the resident in a wheelchair. The resident had an indwelling catheter with the tubing coming out of the left pant leg and connected to a down drain bag hooked to a bar on the back of the chair. The resident propelled the wheelchair independently. Each time the resident used the left foot to move the chair, the indwelling catheter tubing dragged on the floor. In addition, the dignity bag containing the down drain bag was in direct contact with the floor.</p> <p>Interview with Certified Nurse Aide (CNA) #13, on 09/18/13 at 10:05 AM, revealed the indwelling catheter tubing and bag should not be in contact</p>	F 441		



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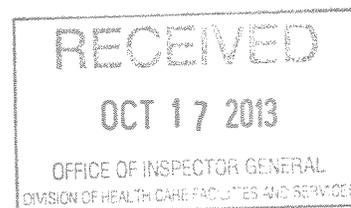
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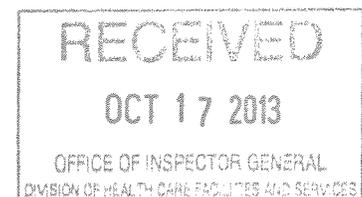
F 441	<p>Continued From page 30</p> <p>with the floor. She stated there were germs on the floor and the indwelling catheter equipment was supposed to remain clean. She stated she had received training on infection control.</p> <p>Interview with LPN #4, on 09/18/13 at 10:30 AM, revealed the nurses supervised the CNAs and had been trained in infection control. The nurse stated indwelling catheter tubing and bags should not touch the floor in order to prevent the spread of infection.</p> <p>Interview with the Director of Nursing, on 09/19/13 at 4:10 PM, revealed nursing staff had received training on infection control and knew indwelling catheter parts were not to be in contact with the floor. She stated this could cause the spread of infection.</p> <p>3. Review of the record for Resident #1 revealed the facility originally admitted the resident on 08/08/08 and readmitted on 04/24/12 with the diagnoses of Ischemic Heart Disease, Hemiplegia, Hypertension, Pain, Urinary Tract Infection, Conversion Disorder and Dementia. The facility determined Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS) on 08/15/13 as part of the Minimum Data Set (MDS) Quarterly assessment to determine cognitive impairment. Resident #1 was diagnosed with a Urinary Tract Infection on 09/12/13 and started on antibiotics on 09/13/13. Extended-Spectrum Beta-Lactamases (ESBL) was confirmed in the urine of Resident #1 on the same date. Isolation precautions were required for the contagious infection ESBL which spreads through contact with an infected patient, object, or surface.</p>	F 441		
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F 441	<p>Continued From page 31</p> <p>Observation, on 09/17/13 during the tour of the facility which began at 8:10 AM, of the room of Resident #1 revealed no isolation cart by the door and no signage on the door to indicate contact precautions were to be in use.</p> <p>Observation, on 09/17/13 at 4:55 PM, revealed no notification for contact precautions for the room of Resident #1. In addition, Certified Nursing Assistant (CNA) #19 was observed going in the room of Resident #1 to do care, did not glove or gown, touched the bed of the resident and assisted Resident #1 with a pillow for his/her neck.</p> <p>4. Review of the record for Resident #22 revealed the facility originally admitted the resident on 07/01/13 and readmitted on 09/04/13 from the hospital with diagnoses of Chronic Kidney Disease, Chronic Airway, Congestive Heart Failure and Clostridium Difficile (C-diff). Resident #22 was not in an isolation room upon readmit from the hospital with C-diff. Contact precautions were not implemented for Resident #22 upon readmit from the hospital. The record revealed no physician order for isolation or any nurses note to indicate Resident #22 would require contact precautions.</p> <p>Observation, on 09/19/13 at 5:07 PM, revealed Resident #22 sitting in his/her room in a wheelchair visiting with a family member. The family member wore no gown or gloves and was sitting on the bed of the resident. An isolation cart was outside the resident's room.</p> <p>Interview, on 09/18/13 at 3:50 PM, with the Staff Development Coordinator revealed she understood Universal Precautions and Contact</p>	F 441		



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F 441	Continued From page 32 Precautions to both mean the same thing. She revealed she had instructed all nurses that came in contact with ESBL or Clostridium difficile (C-diff) to use standard precautions, which she defined as washing hands and wearing gloves. However, the contact precautions needed for residents with ESBL and/or C-diff were not what was practiced in the facility. Interview, on 09/19/13 at 5:10 PM, with the South Nursing Supervisor revealed there were no contact precautions for Resident #1 with identified ESBL and Resident #22 with a C-diff diagnosis until 09/18/13 because it was not identified in the facility that contact precautions were to be in place for the residents with those diagnoses.	F 441		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, with a partial Basement, Type V (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 9/18/13. Georgetown Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X David Bell</i>	TITLE <i>X Administrator X</i> (X6) DATE 10/9/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

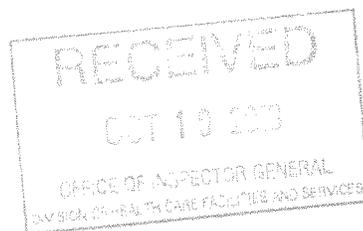
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K 000	Continued From page 1 deficiency identified at D level.	K 000		
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would completely latch when closing, to prevent the passage of smoke in the event of an emergency, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, approximately forty (40) residents, staff, and visitors. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and three (103)</p>	K 018	<p>K-018</p> <p>I. The Maintenance Director and Contractor made repairs to resident room doors 107 and 184 on 9/24/13.</p> <p>II. The Maintenance Director inspected resident room doors for properly closing and checking for removal of trash cans in front of doors on 9/20/13.</p> <p>III. Education was provided to the Maintenance Director by Administrator on 9/20/13 for proper closing of resident room doors and doors not being held open by trash can.</p> <p>IV. The Maintenance Director, Maintenance Assistant and/or Administrator will audit for proper closing of resident room doors and not having trash can in front of door monthly for two months, then quarterly for two quarters. The results of the audit sheets will be reviewed at the quality assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	10/9/2013



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K 018 Continued From page 2 on the day of the survey.

The findings include:

Observations, on 09/18/13 between 9:22 AM and 10:08 AM, with the Maintenance Director revealed the doors to resident rooms 107 and 184 were being held open with trash cans. The doors would self-close when the trash cans were removed.

Interviews, on 09/18/13 between 9:22 AM and 10:08 AM, with the Maintenance Director revealed he was unaware of the doors wanting to self-close and acknowledged the positioning of the trash cans were an impediment to closing the doors in the event of an emergency.

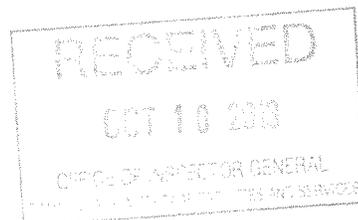
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

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: In smoke compartments

K 018



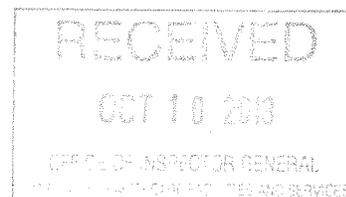
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K 018	Continued From page 3 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 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 018		
K 029 SS=D	19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. NFPA 101 LIFE SAFETY CODE STANDARD 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	K 029	see next page	



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K 029 Continued From page 4
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 meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments on the ground floor, all residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and three (103) on the day of the survey.

The findings include:

Observation, on 09/18/13 at 10:34 AM, with the Maintenance Director revealed the door to the Employee Records Storage Room, within the Staff Development Room located in the Basement, did not have a self-closing device installed on the door.

Interview, on 09/18/13 at 10:34 AM, with the Maintenance Director revealed he was not aware of the door to the Employees Record Storage Room not being equipped with a self-closing device.

K 029 K-029

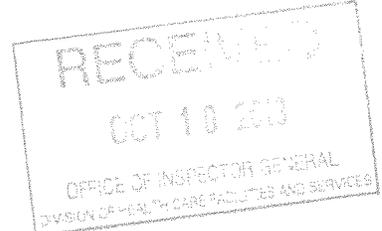
I. The Maintenance Director installed a self closing device to the door to the employee records storage room, within the staff development room located in the basement on 9/18/2013.

II. The Maintenance Director inspected doors requiring self closing devices as required by NFPA 101 (2000 Edition) on 9/20/2013.

III. Education was provided to the Maintenance Director by Administrator on 9/20/13 on doors requiring self closing device.

IV. The Maintenance Director, Maintenance Assistant and/or Administrator will audit facility doors for proper self closing device as required per NFPA 101 Life Safety Code Standard monthly for 2 months then quarterly for two quarters. The results of the audit sheets will be reviewed at the quality assurance meeting for revisions as needed.

V. Completion Date: 10/9/2013



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K 029	Continued From page 5 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 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), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (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 029		

