

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

PRINTED: 09/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125451	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2015
NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 315 SS=D	<p>A standard health survey was conducted on 09/08-10/15. Deficient practice was identified with the highest scope and severity at "F" level.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure and provide appropriate treatment and services to prevent infections of the urinary tract for two (2) of ten (10) sampled residents (Resident #3 and Resident #8). During observations of catheter care for Resident #3, facility staff failed to change gloves and wash hands as required during the provision of incontinence care to Resident #3. In addition, during observation of incontinence care for Resident #8, facility staff placed clean soapy washcloths directly on the resident's headboard before using them to provide incontinence care for Resident #8.</p> <p>The findings include:</p>	F 315	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>1) On 9/15/2015 the Director of Nursing (DON) reviewed resident #3 and resident #8 entire medical records and identified that no adverse outcome was noted from this deficit practice. The facilities staff that was directly involved was immediately in-serviced by the Quality Assurance (QA) Nurse in regards to proper technique and procedure for catheter care and incontinence care. The facilities staff that was directly involved completed a return demonstration with no errors noted.</p> <p>2) On 9/15/2015 all facility nursing staff was audited by the QA Nurse to ensure proper technique and procedure for catheter care and incontinence care. No deficit practice was noted. On 9/15/2015 the DON and QA Nurse audited all residents related to this deficit practice. No residents were identified to have been affected by this practice.</p> <p>3) On 9/15/2015 the Infection Control Nurse in-serviced all State Registered Nurse Aides (SRNA) related to proper technique and procedure for catheter care and incontinence care with return demonstration performed. No deficit practice was noted.</p> <p>4) The corrective action will be monitored as follows, the Infection Control Nurse will complete daily audits five times a week, rotating shifts and personnel. The audits will encompass all the SRNA's on all shifts to ensure proper technique and procedure for catheter care and incontinence care. As part of the facility's QA program the QA Nurse will conduct monthly on-going audits to include every SRNA to ensure proper technique and procedure for catheter care and incontinence care.</p> <p>5) Completion date:</p>	9/25/2015

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

TITLE

(X6) DATE

Robert L. Shaw

CAO

10/02/2015

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 315	<p>Continued From page 1</p> <p>Review of the facility's policy titled "Foley Catheter Care Policy," with a revision date of 01/04/12, revealed staff would remove gloves, discard the gloves into the designated container, wash and dry hands thoroughly, and then put on clean gloves when performing catheter care.</p> <p>1. Review of the medical record revealed Resident #3 was readmitted to the facility on 03/25/15 with diagnoses of Acute Kidney Failure, Neurogenic Bladder, Congestive Heart Failure, Candidiasis, Urinary Retention, Dysuria, and Urinary Tract Infection. Review of the quarterly Minimum Data Set (MDS) assessment dated 06/28/15, revealed the facility assessed Resident #3 to require total assistance with toileting needs and to require an indwelling catheter. Review of the comprehensive care plan dated 04/14/15 revealed the resident required an indwelling catheter with catheter care to be provided every shift and as needed. Review of September 2015 Physician Orders revealed an order for catheter care every shift and as needed related to Urinary Retention and Neurogenic Bladder.</p> <p>Observation of catheter care for Resident #3 on 09/08/15 at 3:50 PM with Certified Nurse Aide (CNA) #1 revealed the CNA washed her hands, put on gloves, and removed the resident's incontinence brief that was soiled with feces. Further observation revealed the CNA cleaned the resident's coccyx area that was soiled with feces. CNA #1 then proceeded to clean the indwelling catheter tubing without washing her hands or applying clean gloves.</p> <p>Interview with CNA #1 on 09/08/15 at 4:00 PM revealed she had been trained to change gloves</p>	F 315			

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F 315	<p>Continued From page 2</p> <p>and wash hands after cleaning a resident's bowel movement and before performing catheter care. The CNA stated she forgot, but should have washed her hands and changed gloves while providing catheter care for Resident #3.</p> <p>2. A review of the facility's policy titled "Bowel and Bladder Incontinence," (not dated) revealed staff would ensure that each resident received the appropriate treatment and services to prevent urinary tract infections. Further review of the policy revealed the policy did not address the procedure for staff to follow to prepare supplies prior to providing incontinence care.</p> <p>Review of the medical record revealed the facility admitted Resident #8 on 09/14/12 with diagnoses including Alzheimer's Disease, Memory Loss, Anemia, End Stage Dementia with Marked Functional Neurological Impairment, and Pyuria. Review of the quarterly MDS assessment dated 08/18/15 revealed Resident #8 required total assistance from staff for toileting. Review of the care plan revealed perineal care should be prompt after each incontinence episode.</p> <p>Observation of incontinence care on 09/10/15 at 3:10 PM revealed Certified Nurse Assistant (CNA) #2 placed clean soapy washcloths on the headboard of the resident's bed before using them to provide incontinence care for Resident #8.</p> <p>Interview with CNA #2 on 09/10/15 at 3:20 PM revealed she had been trained to place the clean washcloths on a clean plastic bag or another type of clean barrier before using them to clean the resident. She further revealed she was nervous and just forgot.</p>	F 315			

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F 315	Continued From page 3 Interview with the Director of Nursing (DON) on 09/10/15 at 5:15 PM revealed competency checks were done yearly with all SRNAs for catheter care. The DON further revealed staff was trained to wash hands and change gloves while cleaning catheter tubing. The DON further stated that staff was trained to place clean washcloths on a clean plastic bag before using them for incontinence care. Additional interview with the DON revealed the facility's quality assurance conducted weekly audits with all SRNAs regarding catheter care and no concerns had been identified.	F 315			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions for twenty-three (23) of twenty-three (23) residents who received meal trays from the kitchen.	F 371	483.35(i)FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1) On 9/15/2015 the Quality Assurance (QA) Nurse reviewed all residents entire medical records and identified that no adverse outcome was noted from this deficit practice. The facilities Dietary Director was immediately in-serviced in regards to proper procedure for completing an audit of the walk in cooler. The Dietary Director completed a return demonstration with no errors noted. 2) On 9/8/2015 all items without open dates were immediately discarded as well as the item with a dirty container. On 9/8/2015 a complete audit of the walk in cooler and walk in freezer was completed by the Dietary Director. No deficit practice was noted. On 9/15/2015 all the facility dietary staff was audited by the QA Nurse to ensure proper procedure for completing an audit of the walk in cooler. No deficit practice was noted. On 9/15/2015 the QA Nurse audited all residents related to this deficit practice. No residents were identified to have been affected by this practice. 3) On 9/15/2015 the QA Nurse in-serviced all Dietary staff related to proper procedure for completing an audit of the walk in cooler with return demonstration performed. No deficit practice was noted. Delivery day audit checklist was re-written to both simplify the process and ensure all areas of concern are noted. The audit checklist is divided between two areas (walk-in refrigerator top right shelf, middle left shelf, etc.) and will be completed every delivery day (twice weekly)by the person putting away stock. The second will focus on all areas from previous sanitation audit and will be done once a week by the person placing the order on Thursdays.		

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F 371	<p>Continued From page 4</p> <p>Observations on 09/08/15 revealed unlabeled and undated foods were being stored in the walk-in cooler. In addition, a container of cocktail sauce was observed to be stored in the walk-in cooler with a gray substance observed on the outside of the container.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Cold Food Storage," dated 07/10/14, revealed all shelf stable items requiring refrigeration after opening were required to be marked with the date the container was opened. The policy also revealed all surfaces would be cleaned and sanitized and staff putting away stock would conduct a sanitation audit every delivery day.</p> <p>Observations on 09/08/15 at 11:10 AM revealed a container of mayonnaise, one (1) container of honey mustard salad dressing, one (1) container of maraschino cherries, and one (1) container of barbecue sauce opened, unlabeled, and undated in the walk-in cooler. In addition, a container of cocktail sauce was observed to be stored in the walk-in cooler with a gray substance observed on the outside of the container.</p> <p>Interview conducted with the Dietary Manager on 09/10/15 at 11:00 AM revealed he was responsible for putting up stock and monitoring to ensure all items had been labeled and dated when opened. The Dietary Manager stated he had completed the last audit on 09/02/15 and had not identified the containers being opened and undated, nor had he identified the gray substance on the outside of the cocktail sauce. The Dietary Manager stated all foods were required to be labeled and dated prior to being placed in the</p>	F 371	<p>Continue From page 4</p> <p>4) The corrective action will be monitored as follows, the Dietary Director will complete daily audits five times a week. The audits will encompass all Dietary staff to ensure proper procedure for completing an audit of the walk in cooler. As part of the facility's QA program the QA Nurse will also conduct monthly on-going audits in the middle of the month. This will include all Dietary staff to ensure proper procedure for completing an audit of the walk in cooler. The Registered Dietitian will also conduct monthly on-going audits at the end of the month. This will ensure proper procedure for completing an audit of the walk in cooler.</p> <p>5) Completion date:</p>	9/25/2015	

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
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F 371	Continued From page 5 walk-in cooler. Interview conducted with the Registered Dietitian (RD) on 09/10/15 at 11:20 AM revealed she was required to do a monthly audit of the kitchen, and she had not identified any concerns with sanitation. The RD stated all foods should be labeled and dated when opened and containers should be clean.	F 371			