

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2014
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
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F 246	Continued From page 59 rooms. Subsequent interview with the DON, on 03/08/14 at 7:56 PM, revealed staff should have made sure the resident had water and the water pitcher was in reach of the resident at all times. She further stated fluids should be available for hydration and healing.	F 246			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents' Comprehensive Care Plans had been followed for two (2) of twenty-four (24) sampled residents (Residents #8 and #18) and one (1) of sixteen (16) Unsampled Residents (Unsampled Resident U). The care plans were not followed for Resident #18 and Unsampled Resident U related to checking for residual (food, liquid or material from a previous feeding left in the stomach at the start of the next feeding) of a gastrostomy tube (g-tube) prior to administration of water and medications. Additionally, Resident #8's care plans for pain and skin integrity were not followed as evidenced by staff failing to notify the Physician of complaints of pain and obtaining an order for pain medication; or not applying Baza Cream (skin protectant) after bowel incontinence	F 282	F282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. N 194 902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment. (4)Comprehensive care plans. (c)The services provided or arranged by the facility shall: 2.Be provided by qualified persons in accordance with each resident's written plan of care. Criteria #1 The enteral feeding tube of Resident #18 and unsampled Resident U is being checked for residual feeding as per facility policy, as determined by care observations completed by the SDC and Administrative Nurses on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14. -Resident #8 was assessed for pain r/t wound status, and orders were obtained for pain medication, as completed by the Unit Manager/Unit Coordinator on 3/10/14 Manager/Unit Coordinator on 3/10/14. Pain medication is administered and Baza ointment is applied as ordered as determined by care observations completed by the SDC and Administrative Nurses on March 24, 25,26, 27,28, 29, 31 and April 2, 4 and 6. Criteria #2 All residents with feeding tubes have the potential to be affected by this alleged deficient practice.		

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F 282	<p>Continued From page 60 care.</p> <p>The findings include:</p> <p>Review of the facility's policy: "MDS (Care Plan) Process", undated, revealed all nursing staff were to follow the care plan and implement all interventions.</p> <p>Review of the facility's policy titled, "Licensed Nurses Assessment/Care Planning/Physician's Orders", undated, revealed the care plan was developed and was to list all interventions for each resident which were to be followed by the appropriate staff. Further review revealed it was important the staff was aware of care plan interventions; and provided care in accordance with the care plan.</p> <p>1. Review of Unsampled Resident U's medical record revealed the facility admitted the resident on 07/12/06, with diagnoses which included Cerebral Artery Occlusion with Infarct, Aphasia, Hemiplegia, Diabetes, Hypertension, and Status Post Gastrostomy.</p> <p>Review of Unsampled Resident U's Comprehensive Care Plan revealed interventions for the nurse to observe for any signs and symptoms or complications with the g-tube which included consistent large amounts during residual checks; and check residual before flushes and/or medications.</p> <p>Observation during a medication pass for Unsampled Resident U, on 03/06/2014 at 5:25 PM, revealed Registered Nurse (RN) #3 checked placement of the g-tube prior to administration of the medication; however, the nurse did not check</p>	F 282	<p>- All residents with wounds were assessed for pain, with review of orders to determine that pain medication is ordered as needed, as completed by the Unit Managers/Unit Coordinators on 3/18/14, 3/25/14, and 4/4/14.</p> <p>-All residents with orders for protective ointments after bowel incontinence have the potential to be affected by the alleged deficiency.</p> <p>-Weekly care observations by Administrative nurses as completed on March 24, 25,26, 27,28, 29, 31 and April 2, 4 and 6 and daily SRNA walking rounds as completed from 3/17/14 - 4/8/14 and ongoing will identify any further issues r/t implementation of the care plan and C.N.A care plan. Staff will address the identified issues timely, or report them to Administrative Nurses</p> <p>Criteria #3</p> <p>- All facility nurses have received in-service education on following the care plan interventions including but not limited to the enteral feeding tube policy and procedure for checking residual feedings on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, and 4/2/14, 4/4/14 and 4/6/14 as provided by the SDC. All nurses were required to perform a return demonstration for this procedure. Any/All new hire licensed nurses will receive education and will be required to successfully perform a return demonstration of the procedure for checking residual feedings before they are allowed to provide enteral feeding care and/or meds.</p> <p>- All licensed nurses have received inservice education on following the care plan interventions including but not limited to the need to assess residents for pain when providing care, to obtain orders for pain medications as indicated, and to administer pain medications in accordance with MD orders, as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14, and 4/6/14.</p>		

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F 282	<p>Continued From page 61</p> <p>for residual. RN #3 proceeded to flush the g-tube with water and met resistance. RN #3 tried unsuccessfully to unclog the g-tube, and had to obtain a de-clotter to thread through the g-tube prior to finally administering the medication and water flushes. Continued observation revealed RN #3 had not checked the residual in the resident's stomach throughout the procedure as per the Comprehensive Care Plan.</p> <p>2. Review of Resident #18's medical record revealed the facility admitted the resident on 08/19/10, with diagnoses which included Multiple Sclerosis, Muscular Wasting and Disuse Atrophy, Status Post Gastrostomy, Dysphagia Oropharyngeal Phase, Aspiration Pneumonia, Gastric Intestinal (GI) Bleed and Parkinson's Disease.</p> <p>Review of Resident #18's Comprehensive Care Plan, dated 02/02/14 revealed interventions for the nurse to have observed for any signs and symptoms or complications with the g-tube which included consistent large amounts during residual checks; and check residual before flushes and/or medications.</p> <p>Observation during a medication pass, on 03/06/2014 at 5:45 PM, revealed RN #3 checked for placement of Resident #18's g-tube prior to administration of the medication; however, the nurse had not checked for residual as per the care plan. RN #3 proceeded to flush the g-tube with water and met resistance. Continued observation revealed RN #3 tried unsuccessfully to unclog the g-tube, and had to obtain a de-clotter to unclog the g-tube prior to administering the medications and water flushes. Further observation revealed RN #3 did not check</p>	F 282	<p>-All SRNA staff have received inservice education on the need to follow the MD orders identified on the C.N.A. care plan, including but not limited to application of protective ointments after bowel incontinence, as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/31/14, and 4/4/14.</p> <p>-Newly hired SRNA and Licensed nursing staff will receive the education identified above as part of the orientation program, as provided by the SDC.</p> <p>Criteria #4 -The CQI Tools are included for review as Attachment N-3, N-11 and N-22, and N-26. The CQI Tools address compliance with the entire regulation, and are completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.</p> <p>Criteria #5 April 9, 2014.</p>		

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F 282	<p>Continued From page 62 for residual throughout the procedure as per the care plan.</p> <p>Interview with RN #3, on 03/07/14 at 4:40 PM, revealed she usually checked for residual prior to the administration of medication and water. She stated she did not know why she had not checked for residual on 03/06/14, prior to administering Resident #18's and Unsampled Resident U's medications as per the care plan. She further stated she should have done so.</p> <p>Interview with RN #2, on 03/17/14 at 5:45 PM revealed she was the Unit Coordinator for the unit where Resident #18 and Unsampled Resident U resided. She stated her expectation was for all nurses to check the amount of residual prior to the administration of any fluid or medication through the g-tube, as per the care plan.</p> <p>Interview with the Director of Nursing, on 03/08/14 at 2:10 PM, revealed her expectation was for nursing staff to check residual before the administration of any fluid or medication through the g-tube, per the care plan. She further indicated her expectation was for the nursing staff to follow residents' care plans and the facility's policy to ensure care provided met the residents' needs.</p> <p>3. Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/13, with diagnoses which included Alzheimer's Disease, Depression, Chronic Kidney Disease, Diabetes, Peripheral Vascular Disease (narrowing of blood vessels that restricts blood flow) and Bilateral Lower Limb Above the Knee Amputation. Further review revealed the resident had been re-admitted to the facility on 02/26/14,</p>	F 282			

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F 282	<p>Continued From page 63</p> <p>following a hospital stay, with diagnoses which included Pneumonia, Hematuria and Urinary Retention.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/23/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5) which indicated the resident was severely cognitively impaired. Further review of the MDS revealed the facility assessed the resident as having no pain during the assessment period. However, review of the Significant Change Comprehensive MDS Assessment dated 10/30/13, revealed the facility assessed the resident to have had occasional, moderate pain.</p> <p>Review of Resident #8's Admission Care Plans dated 02/26/14, revealed the resident had a care plan for skin integrity with interventions which included providing incontinence care and barrier (skin protectant) cream as needed. Further review of the Admission Care Plan revealed Resident #8 had a pain care plan with interventions to monitor pain, administer pain medications as ordered and if no pain medication order, notify the Physician.</p> <p>Observation on 03/05/14 at 11:10 AM of Resident #8's bowel incontinence care, performed by State Registered Nursing Assistant (SRNA) #19, and observation of the resident's skin assessment performed by Licensed Practical Nurse (LPN) #3/Wound Treatment Nurse, revealed the resident complained of hurting when SRNA #19 wiped the resident's buttocks and when the LPN performed an assessment of an area of redness on the buttocks. Continued observation revealed after SRNA #19 performed the resident's bowel</p>	F 282		

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F 282 Continued From page 64
incontinence care did not apply Baza Barrier Cream (skin protectant) to the buttock area, per the care plan.

Interview with SRNA #19, on 03/08/14 at 5:36 PM and 6:55 PM, revealed after providing Resident #8's incontinence bowel care on 03/05/14, she had not applied the barrier cream to the resident's buttocks as she thought the LPN would apply it.

Interview with SRNA #20, on 03/08/14 at 2:22 PM, revealed she was usually assigned to care for Resident #8. She stated the nurse normally applied the barrier cream (Baza) to the resident; however, since the resident's re-admission she had not noticed any Baza cream applied.

Interview with SRNA #17, on 03/08/14 at 2:35 PM, revealed she was assigned to Resident #8's care at times. She stated the barrier cream was in the resident's drawer for use, but she had not applied Baza Cream when she changed the resident.

Interview with SRNA #16, on 03/08/14 at 5:21 PM, revealed she routinely cared for Resident #8. She stated the resident would tell staff if he/she had pain when they turned or changed the resident. The SRNA further stated he had told the nurse about the resident's pain complaints before.

Interview with LPN #8, on 03/08/14 at 5:55 PM, revealed prior to going to the hospital the resident had not complained of pain; however, the resident had complained of hurting when they were in the room doing the skin assessment and incontinence care on 03/05/14.

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F 282	Continued From page 65 Interview with LPN #1, on 03/08/14 at 6:16 PM, revealed she took care of Resident #8 and the resident had not complained of pain and had no pain medication ordered since he/she had been re-admitted. The LPN stated if the pain care plan had interventions to administer pain medication or notify the Physician, the nurse should have followed the care plan and obtained an order for pain medication when the resident complained of pain. Interview on 03/08/14 at 6:29 PM, with Registered Nurse (RN) #2/Unit Manager West Wing where Resident #8 resided, revealed the care plan had the intervention for Baza cream to be applied each shift and as needed. She stated staff had not followed the care plan if the Baza cream had not been applied after the incontinence care was done. Continued interview revealed Resident #8's pain should have been addressed by staff, and everyone was to ensure care plans were followed. She indicated if staff had observed the resident complaining of pain, an order for pain medication should have been obtained, as per the care plan. Interview with the Director of Nursing (DON) on 03/08/14 at 6:45 PM, revealed Resident #8 previously had a PRN (as needed) pain medication ordered. She stated if a resident had a pain care plan, they normally had a pain medication order. Continued interview revealed if Resident #8 had complained of pain, the nurses should have addressed the pain and followed the pain care plan. The DON further stated the nurses were to ensure care plans were followed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 Each resident must receive and the facility must provide the necessary	

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F 309	Continued From page 66 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of twenty-four (24) sampled residents (Resident #8). Observation during performance of incontinence care and a skin assessment on 03/05/14, revealed Resident #8 complained of pain and had been care planned for pain. However, review of the Physician's Orders revealed no documented evidence the Physician had been notified and pain medication ordered. The findings include: Review of the facility's policy titled, "Pain Management Policy and Procedure", undated, revealed residents were to be assessed for their level of pain, and were to be monitored for the effectiveness of pain management therapy. Further review of the policy revealed as needed (PRN) pain medications were to be administered as indicated.	F 309	care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan. N 199 902 KAR 20:300-8 Section 8. Quality of Care. Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident shall receive services and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Criteria #1 Resident #8 was assessed for pain r/t wound status, and orders were obtained for pain medication, as completed by the Unit Manager/Unit Coordinator on 3/10/14. Pain medication is administered and Baza ointment is applied as ordered as determined by care observations completed by the SDC and Administrative Nurses on March 24, 25, 26, 27, 28, 31 and April 4. Criteria #2 All residents with wounds were assessed for pain, with review of orders to determine that pain medication is ordered as needed, as completed by the Unit Managers/Unit Coordinators on 3/18/14, 3/25/14 and 4/4/14. -Monthly care observations by Administrative Nurses and daily SRNA walking rounds will	

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F 309	Continued From page 67 Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/13 with diagnoses which included Alzheimer's Disease, Depression, Diabetes, Peripheral Vascular Disease (narrowing of blood vessels that restricts blood flow) and Bilateral Lower Limb Above the Knee Amputation. Continued review of the record revealed Resident #8 had been hospitalized and re-admitted to the facility on 02/26/14. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/23/14, revealed the facility had assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated severe cognitive impairment. Review of Resident #8's Comprehensive Care Plan revealed a care plan for pain with a stated goal to ensure the resident was kept as comfortable as possible. Continued review of the pain care plan revealed the interventions included: monitoring pain; administering pain medications as ordered; and notifying the Physician if no pain medication had been ordered. Review of Resident #8's monthly Physician Orders for February 2014, revealed an order for Percocet (pain medication) 5/325 milligram (mg) tablet to have been administered every four (4) hours when needed for pain. However, review of the Physician's Orders revealed when the resident was re-admitted on 02/26/14, the Physician's Orders did not include orders for pain medication. Review of Resident #8's Pain Assessment Observation Profile for February 2014 and March 2014, since his/her re-admission to the facility, revealed no documented evidence the resident had been assessed as having had	F 309	identify any further issues r/t implementation of the careplan and C.N.A care plan. Staff will address the identified issues timely, or report them to Administrative Nurses. Criteria #3 All licensed nurses have received inservice education on the need to provide all care in accordance with the care plan including but not limited to assess residents for pain when providing care, to obtain orders for pain medications as indicated, and to administer pain medications in accordance with MD orders, as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14. -Newly hired SRNA and Licensed nursing staff will receive the education identified above as part of the orientation program, as provided by the SDC. Criteria #4 Care observations will be completed monthly by Administrative Nursing to determine that care plan interventions are being consistently implemented. Results will be reported by the DON to the QA committee monthly. The CQI Tools are included for review as Attachment N-3 and N-26. The CQI Tools address compliance with the entire regulation, and are completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action. Criteria #5 April 9, 2014.		

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F 309	<p>Continued From page 68</p> <p>pain.</p> <p>Interview with Licensed Practical Nurse (LPN) #14, on 03/08/14 at 7:40 PM, revealed when she called the Advanced Practice Registered Nurse (APRN) on 02/26/14 to verify the re-admission orders, they had discussed the previously ordered pain medication. The LPN stated since record review revealed the pain medication had only been administered one (1) time in two (2) months prior to hospitalization, in January and February 2014, the APRN informed the nurse to wait to see if a pain medication was needed and had not renewed the pain medication order.</p> <p>Observation of bowel incontinence care, on 03/05/14 at 11:10 AM, revealed Resident #8 complained of pain when State Registered Nursing Assistant (SRNA) #19 cleansed the resident's buttock area. In addition, observation during the skin assessment performed by LPN #3, revealed Resident #8 complained of hurting when the LPN assessed an area of redness on the resident's buttock.</p> <p>Interview on 03/08/14 at 5:21 PM, with SRNA #16 who routinely cared for Resident #8, revealed Resident #8 complained of pain at times. SRNA #16 stated Resident #8 told staff if he/she was in pain when they were turning or changing the resident. The SRNA further stated he had told the nurse of Resident #8's complaints of pain.</p> <p>Interview with LPN #8, on 03/08/14 at 5:55 PM, revealed before the resident had gone to the hospital he/she had not complained of pain. LPN #8 stated when staff performed the skin assessment and incontinence care on 03/05/14, the resident had complained of hurting at that</p>	F 309		

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F 309	<p>Continued From page 69 time.</p> <p>Interview with LPN #1, on 03/08/14 at 6:16 PM, revealed she cared for Resident #8 and had known Resident #8 to have complaints of pain. LPN #1 stated Resident #8 currently had no pain medication ordered. The LPN stated if Resident #8's pain care plan had interventions which included administering pain medication, or notifying the Physician, the nurse who had witnessed the resident to have pain should have obtained an order for pain medication.</p> <p>Interview on 03/08/14 at 6:29 PM, with Registered Nurse (RN) #2/Unit Manager West Wing where Resident #8 resided, revealed if Resident #8 was experiencing pain, it should have been addressed as the facility wanted to ensure the resident was as pain free as possible. RN #2 stated the Wound Nurse performing the skin assessment on 03/05/14 should have documented any complaints of pain by Resident #8, and notified the Physician of the resident's pain and requested pain medication for the resident. The RN stated at the very least the Wound Nurse should have communicated Resident #8's pain complaint to the nurse on the hall. She further stated everyone was supposed to ensure Resident #8's care plan for pain was followed. Continued interview revealed, if the resident was in pain there should have been an order obtained for pain medication.</p> <p>Interview with the DON, on 03/08/14 at 6:45 PM, revealed she had heard SRNA #19 reported Resident #8 had complained of pain with bowel incontinence care. She stated she had not been aware the resident currently had no PRN (as needed) pain medication ordered. She further</p>	F 309		

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F 309	Continued From page 70 stated she knew Resident #8 had previously had a PRN pain medication. Continued interview revealed if a resident had a pain care plan, the resident normally had a pain medication ordered. The DON revealed her expectation was for residents' complaints of pain to be addressed by staff to ensure residents' comfort; the nurses should have documented Resident #8's complaints of pain and obtained a pain medication order to ensure the resident was comfortable.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident having pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing for one (1) of twenty-four (24) sampled residents (Resident #8). Observation on 03/05/14, of Resident #8's skin assessment, performed by the wound nurse, revealed an unidentified Stage II Pressure Ulcer to the resident's upper right buttock area.	F 314	F 314 Pressure Ulcers Based on the Comprehensive Assessment of a resident, the facility must ensure that- 1)A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2) A resident who has an ulcer receives care and services to promote healing and to prevent additional ulcers. N 211 902 KAR 20:300-8(3)(b) Section 8. Quality of Care (3) Pressure sores. Based on the comprehensive assessment of a resident the facility shall ensure that: (b)A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Criteria 1: On 4/6/14 a full skin assessment was performed on Resident #8. At that time the stage II wound was healed and no other skin issues were identified.		

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F 314	<p>Continued From page 71</p> <p>Interviews with the resident's nurse and the Wound Nurse revealed they were unaware of the Pressure Ulcer. However, a State Registered Nursing Assistant (SRNA) reported she had observed the open area when she had given the resident a bath that morning and noted her observation on the shower sheet. The SRNA waited an hour before informing the resident's nurse. In addition, the resident was supposed to have Baza Cream (skin protectant cream) applied after incontinence care; observation during care provided on 03/05/14 revealed no Baza Cream had been applied.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Wound Care Policy", undated, revealed the facility had a system in place for identifying residents at risk for Pressure Ulcer development, and implementing preventive/supportive precautions to maintain skin integrity. Further review of the policy under the "Resident Skin Assessment Form Instructions" revealed any new or worsening areas were to be reported immediately to the Physician/Advanced Registered Nurse Practitioner and family.</p> <p>Interview, on 03/08/14 at 6:45 PM, with the Director of Nursing (DON) revealed her expectation if a resident experienced a change in their condition, such as a new Pressure Ulcer, staff was to notify the Physician's office within thirty (30) minutes of identification of the change.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/13 with diagnoses which included Diabetes, Peripheral Vascular Disease (narrowing of blood vessels</p>	F 314	<p>Criteria 2: Head to toe skin assessments were completed on all in house residents to determine that all identified skin issues were accurately documented with appropriate treatments in place, as conducted by the DON/SDC/Unit Managers/Unit Coordinators on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/30/14, 4/2/14, 4/4/14 and 4/6/14. All residents with orders for Protective ointments after bowel incontinence have the potential to be affected by the alleged deficiency.</p> <p>Criteria 3: Facility nursing staff have received inservice education on skin assessment protocols, including but not limited to: correct completion and documentation of head to toe skin assessments; observations of skin during care with timely reporting of all findings to the wound nurse; and the need to address skin issues reported by the SRNA staff timely as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14.</p> <p>-All SRNA staff have received inservice education on the need to follow the MD orders identified on the C.N.A. care plan, including but not limited to application of protective ointments after bowel incontinence, as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14 and 4/4/14.</p> <p>-Newly hired SRNA and Licensed nursing staff will receive the education identified above as part of the orientation program, as provided by the SDC.</p>		

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F 314	Continued From page 72 which restricted blood flow) Chronic Kidney Disease and Bilateral Lower Limb Above the Knee Amputation. Continued review revealed Resident #8 had experienced a hospitalization and had been readmitted to the facility on 02/26/14. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/23/14, revealed the facility assessed Resident #8 as having a Brief Interview for Mental Status (BIMS) score of five (5) which indicated severe cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #8 as at risk for Pressure Ulcer development; and had interventions in place which included a pressure reduction mattress, chair cushion and application of skin protectant ointments. Review of the Significant Change MDS Assessment dated 10/30/13, revealed the facility had identified conditions which included limited bed mobility, incontinence, history of sacral wound and refusal of care, which had triggered Pressure Ulcers on the Care Area Assessments which resulted in care plan development for impaired skin integrity. Review of the Comprehensive Care Plan dated 11/05/13, revealed Resident #8 had a care plan for impaired skin integrity which had been updated on 12/31/13, to indicate the resident had Stage II Pressure Ulcers to the left and right buttock. Continued review of the care plan revealed it had been discontinued on 01/04/14 due to the Pressure Ulcers having been healed. Review of the Admission Care Plan dated 02/26/14, created when Resident #8 returned to the facility after hospitalization, revealed it included a care plan for risk for impaired skin integrity with interventions which included encouraging the resident to turn and reposition every two (2)	F 314	Criteria 4: -Skin assessment Monitoring (review of skin assessment findings to verify accuracy) will be completed on 1 resident per unit weekly X 4 weeks, then monthly X 2 months to determine accurate completion and documentation of skin assessment findings, as conducted by the DON/SDC/Administrative Nurses, by randomly selecting residents by room number. -The CQI Tool is included for review as Attachment N-3. The CQI Tool addresses compliance with the entire regulation, and is completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action. Criteria 5: April 9, 2014.		

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F 314	<p>Continued From page 73</p> <p>hours; providing incontinence care after each episode; and barrier cream (skin protectant cream) as needed. Further review of this care plan revealed no documented evidence of Resident #8 having had any current skin breakdown.</p> <p>Review of Resident #8's prior skin assessments for Feb 2014 revealed no documentation related to Pressure Ulcer; however review of the readmission skin assessment dated 02/26/14, revealed Resident #8 had been assessed to have had areas of denuded (excoriated or eroded) skin on the left and right buttocks.</p> <p>Review of Resident #8's March 2014 monthly Physician Orders revealed orders for a comfort support saddle cushion to the resident's wheelchair, a turning wedge for positioning in the bed, and application of Baza cream to the buttocks and perineal area every shift and as needed.</p> <p>Observation, on 03/05/14 at 11:10 AM, of Resident #8's skin assessment, performed by Licensed Practical Nurse (LPN) #3/Wound Treatment Nurse, revealed a Stage II Pressure Ulcer which was noted as 2.0 centimeters (cm) in length by 1.8 cm width by less than 0.1 cm in depth to the upper right buttock. Continued observation revealed Resident #8 had a red blanchable area to the left buttock. Additionally, observation revealed SRNA #19 performed bowel incontinence care for Resident #8 at the time of the skin assessment; however the SRNA did not apply the Baza Barrier Cream to the resident's buttock area.</p> <p>Interview, on 03/05/14 at 7:46 PM, with LPN</p>	F 314		

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F 314	<p>Continued From page 74</p> <p>#3/Wound Treatment Nurse revealed Resident #8 had a Stage II Pressure Ulcer to the right buttock which had a dark wound base and even edges. The LPN stated she had not been aware of the Stage II Pressure Ulcer prior to the skin assessment. She stated staff was to notify her of any new skin concerns which might have been considered a Pressure Ulcer. The LPN also stated Resident #8 had been at risk for Pressure Ulcers to his/her buttocks as he/she had experienced prior skin breakdown to the area.</p> <p>Interview, on 03/08/14 at 3:50 PM, with LPN #6, who had provided care for Resident #8 on 03/05/14, revealed if SRNAs became aware of a change in the resident's skin condition they were to notify the nurse. She stated nobody told her anything about an open area or red area on Resident #8's buttocks.</p> <p>Interview, on 03/08/14 at 5:21 PM, with SRNA #16, who cared for Resident #8 routinely, revealed the resident had behaviors at times; and staff was not always able to turn and reposition him/her every two (2) hours related to the resident's refusal and cursing at staff. The SRNA stated before 03/05/14 the resident had red areas on his/her buttocks; and one (1) time the Wound Nurse went with him and checked the resident. SRNA #16 stated the areas on the resident's buttocks became more reddened after that; however since the Wound Nurse had went with him and checked the resident, he had not told the other nurses. He indicated he did put the cream on Resident #8's buttocks after incontinence care.</p> <p>Interview, on 03/08/14 at 5:36 PM and 6:55 PM, with SRNA #19 revealed she had given Resident</p>	F 314			

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F 314	<p>Continued From page 75</p> <p>#8 a bed bath the morning of 03/05/14; and observed the resident as having had an open area on his/her right buttock toward the middle, and a red area on the left buttock. SRNA #19 stated she documented what she had observed on the Shower Sheet and had told the nurse about an hour after the bed bath. She stated however, SRNAs were supposed to notify the nurse immediately when they observed a change. Further interview with the SRNA revealed after incontinence bowel care on 03/05/14, she had not applied the barrier cream to Resident #8's buttocks as she thought the LPN would apply the cream.</p> <p>Review of Resident #8's Shower Sheet, dated 03/05/14, untimed, revealed documentation which stated the resident had redness and an open area and the nurse had been notified. Continued review of the shower sheet revealed the nurse providing care for Resident #8 had signed and dated the shower sheet; however further review revealed no documented evidence the nurse had completed the nurse assessment area on the Shower Sheet.</p> <p>Interview, on 03/08/14 at 6:29 PM, with Registered Nurse (RN) #2/Unit Manager West Wing, where Resident #8 resided, revealed SRNAs were supposed to bring the Shower Sheet to the nurse right after the shower. The RN stated Resident #8's Shower Sheet showed his/her buttock had been red and there had been an open area and the nurse had signed off on the Shower Sheet. RN #2 stated the nurse should have assessed the area, documented the findings and notified the Physician. The RN indicated however there had been no documentation this had been completed.</p>	F 314		

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F 314	Continued From page 76 Continued interview with RN #2 revealed the care plan indicated Baza cream was to have been applied each shift and as needed; and staff should have applied the Baza cream to the buttock area after the bowel incontinence care. She stated by not applying the Baza cream staff had not followed Resident #8's care plan. Interview with the DON, on 03/08/14 at 6:45 PM, revealed SRNAs should have notified the nurse immediately and not waited an hour before reporting the change in Resident #8's skin. After reviewing the Shower Sheet for 03/05/14, the DON stated it looked like SRNA #19 had notified the nurse; but the nurse had not assessed the site. She further stated staff had not notified the Physician, in a timely manner for new treatment; and had not notified the wound nurse of the open area. The DON also stated after the incontinence care on 03/05/14 staff should have applied the Baza Cream for protection. Interview, on 03/08/14 at 10:41 AM, with the Medical Director revealed skin issues could progress rapidly, and if nursing assistants identified a skin issue they should let the nurse know immediately so the area of concern could be evaluated.	F 314			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was	F 322	Treatment/Services-Restore Eating Skills. Based on the comprehensive assessment of a resident, the facility must ensure that- (1)A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable.		

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F 322	Continued From page 77 unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident who was fed by a gastrostomy tube (g-tube) received the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities. Resident #18's March 2014 monthly Physician orders had an order for "Two Cal HN" tube feeding at fifty (50) milliliters (mls) per hour for twenty-two (22) hours per day; and an order to flush the g-tube with two hundred and seventy-five (275) mls of water every four (4) hours. The Medication Administration Record (MAR) dated March 2014 revealed no documented evidence the tube feeding was to be off for two (2) hours in a 24 hour period. In addition, there was no documentation on the MAR to indicate when the water flushes were to be administered which were ordered every four	F 322	N 236 902 KAR 20:300-8(12)(b) Section 8. Quality of Care. (12)Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that: (b)A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. Criteria #1 Orders for enteral flushes have been clarified by the Unit Managers/Unit Coordinators to reflect the provision of flush fluids continuously via pump for Resident #18 and unsampled Resident U. Resident #18 and unsampled Resident U are provided enteral feedings in accordance with MD orders, with residuals checked as per facility protocol as determined by care observations completed by the SDC/Administrative Nurses on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14 and 4/4/14. Criteria #2 All residents with enteral feedings have the potential to be affected by this alleged deficiency as determined by the care observations done on the dates listed above. -Orders for enteral flushes have been clarified by the Unit Managers/Unit Coordinators to reflect the provision of flush fluids continuously via pump. Criteria #3 Inservice education was provided for all licensed nurses on the provision of enteral feedings in accordance with MD orders, and the facility protocol for the checking of residuals		

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F 322 Continued From page 78
(4) hours for a total of two hundred and seventy-five (275) mls in a twenty-four (24) hour period. Interviews with the nurses assigned to Resident #18 revealed they did not know what time the tube feeding was to be stopped for two (2) hours a day, and stated they just ensured the tube feeding was held during patient care.

Also, observation during the medication pass revealed the nurse failed to check the g-tube for residual prior to water flushes and medication administration for Resident #18 and Unsampled Resident U.

The findings include:

Review of the facility's policy titled, "Specific Medication Administration Procedures, IIB13: Enteral Tube Medication Administration", revised 12/07/12, revealed the facility's policy was to safely and accurately administer oral medications through an enteral tube. Continued review of the policy revealed it indicated prior to flushing the g-tube with water and prior to medication administration the nurse was to check the gastric contents for residual tube feeding.

Interview with the Director of Nursing (DON) on 03/08/14 at 2:10 PM, revealed the facility had no policy for the transcription of Physician's Orders or the administration of tube feedings.

1. Review of Resident #18's medical record revealed the facility admitted the resident on 08/19/10, with diagnoses which included Multiple Sclerosis, Dysphagia Oropharyngeal Phase, Aspiration Pneumonia and Status Post Gastrostomy. Review of Resident #18's Comprehensive Plan of Care dated 02/02/14,

F 322 and writing enteral flush orders as provided by the SDC on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14. -Newly hired Licensed nursing staff will receive the education identified above as part of the orientation program, as provided by the SDC.

Criteria #4 The CQI Tool is included for review as Attachment N-11. The CQI Tool addresses compliance with the entire regulation and is completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.

-In addition, CQI indicator N-13 for Special Procedure observations, was completed on 4/7/14, and will be utilized for the monitoring of feeding tube care quarterly under the supervision of the DON.

Criteria #5 April 9, 2014.

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F 322 Continued From page 79
revealed interventions for the nurse to observe for and report any signs and symptoms of complications with the g-tube which included monitoring for consistent large amounts with residual checks and checking the residual before flushes and/or medications.

Review of Resident #18's Physician Orders revealed on 02/19/14 Physician's Orders had been written to flush the g-tube with two hundred and seventy-five (275) ml's of water every four (4) hours. Review of the Physician's Order dated 02/24/14 revealed an order for Resident #18's "Two Cal HN" tube feeding to be decreased to fifty (50) ml's per hour for twenty-two (22) hours per day. Review of the March 2014 monthly Physician's Orders revealed these orders had been carried over to the monthly orders.

Review of Resident #18's February and March 2014 Treatment Administration Record (TAR) revealed the order for the "Two Cal HN" at fifty (50) ml's per hour for twenty-two (22) hours per day had been recorded; and nurses had initialed the order as performed for each shift which included the 7:00 AM to 3:00 PM shift, 3:00 PM to 11:00 PM shift and 11:00 PM to 7:00 AM shift. Continued review revealed the order to flush the g-tube with two hundred and seventy-five (275) ml's of water every four (4) hours had been recorded; and nurses had initialed the order as performed on all three (3) shifts. However, review of the TARS revealed no documented evidence of when Resident #18 was to be disconnected from the tube feedings for two (2) hours; and no documented specified times for the two hundred and seventy-five (275) ml water flushes every four (4) hours. Review of the Medication Administration Records (MAR) and

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F 322	Continued From page 80 Nurse's Notes revealed no documented evidence of when the tube feeding had been disconnected for the two (2) hours; and no documented evidence of the precise times of administration of the water flushes. A review of Resident #18's "Enteral Intake" (g-tube feeding intake) sheet, dated March 2014 revealed the resident had the order for the "Two Cal HN" at fifty (50) ml's per hour for twenty-two (22) hours per day. Review of the sheet revealed the total the resident was to have received was documented as one thousand and one hundred (1100) ml's in a twenty-four (24) hour period. Continued review revealed the order for the two hundred and seventy-five (275) ml's of water flushes every four (4) hours. Review of the sheet revealed the total the resident was to have received was documented as one thousand six hundred and fifty (1650) ml's in a twenty-four (24) hour period. Further review of the "Enteral Intake" sheet revealed on 03/01/14 the resident had received one thousand and two hundred (1200) ml's of tube feeding, and one thousand eight hundred and forty (1840) ml's of water; on 03/02/14 the resident had received one thousand and two hundred (1200) ml's of tube feeding, and one thousand eight hundred and forty (1840) ml's of water; on 03/03/14 the resident had received one thousand and two hundred (1200) ml's of tube feeding, and one thousand seven hundred and eighty (1780) ml's of water. Further review of the "Enteral Intake" sheets revealed no documented evidence the Physician's Orders for Resident #18's tube feeding and water flushes had been followed as evidenced by the twenty-four hour totals exceeding the totals indicated which placed the resident at a higher risk for g-tube complications.	F 322			

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F 322 Continued From page 81

Interview with Registered Nurse (RN) #3 on 03/07/14 at 4:40 PM, revealed there had been no specific time documented of the precise two (2) hours for when Resident #18 was to have been disconnected from the tube feeding. She stated however, the resident's tube feeding was disconnected during personal care. RN #3 also stated, she administered two hundred and seventy-five (275) ml's of water in Resident #18's g-tube twice during her shift; however could not recall the precise time.

An interview with Licensed Practical Nurse (LPN) #2 on 03/08/14 at 2:45 PM revealed when she received a Physician's Order she filled out the order sheet, notified the family and placed the order on the medical record. She stated she then transcribed the order to the MARs and TARs and documented the order on the Nurse's Notes. She indicated if the order was for a change in the tube feeding rate she would change the rate on the tube feeding pump also. LPN #2 stated residents were usually disconnected from the tube feeding for personal care. LPN #2 indicated she was not sure why the facility did not document the two (2) hours Resident #18 was supposed to have been off the g-tube feeding, or the precise times for the water flushes.

Interview, on 03/17/14 at 5:45 PM, with RN #2/Unit Coordinator (UC), of the unit on which Resident #18 resided, revealed she did not know why the precise two (2) hours Resident #18 was to have been disconnected from the tube feeding had not been recorded. RN #2/UC also stated she did not know why there had not been precise timing of the two hundred and seventy-five (275) ml water flushes every four (4) hours. She stated

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F 322	<p>Continued From page 82</p> <p>she would immediately make the necessary changes to the TAR; and speak with the nurses regarding the issue.</p> <p>2. Review of Resident #18's Comprehensive Plan of Care dated 02/02/14, revealed interventions for the nurse to observe for and report any signs and symptoms of complications with the g-tube which included monitoring for consistent large amounts with residual checks and checking the residual before flushes and/or medications.</p> <p>Observation of a medication pass for Resident #18 on 03/06/14 at 5:45 PM, revealed RN #3 checked for placement of the g-tube prior to administration of the medication; however, the nurse did not check for the residual. RN #3 attempted to flush the g-tube with water and met resistance; and tried unsuccessfully to unclog the g-tube. RN #3 was observed to obtain a g-tube de-clotter and thread it through the g-tube unclogging it. The nurse was then observed to administer the medications and water flushes. Continued observation revealed RN #3 did not check the residual in the resident's stomach throughout the procedure, to assess how well the resident had been tolerating the tube feedings and medications administered; as per the care plan.</p> <p>3. Review of Unsampled Resident U's medical record revealed the facility admitted the resident on 07/12/06, with diagnoses which included Aphasia, Status Post Gastrostomy, Cerebral Artery Occlusion with Infarct and Diabetes. Review of Unsampled Resident U's Comprehensive Care Plan revealed interventions for the nurse to observe for and report any signs</p>	F 322		

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F 322	<p>Continued From page 83</p> <p>and symptoms or complications with the g-tube which included consistent large amounts with residual checks, and to check residual before flushes and/or medications.</p> <p>Observation of medication pass for Unsampled Resident U, on 03/06/14 at 5:25 PM, revealed RN #3 was observed to check for placement of the g-tube prior to administration of the medication; however, the nurse did not check for the residual in Unsampled Resident U's stomach. Continued observations revealed RN #3 proceeded to flush the g-tube with water and met resistance. Observation revealed RN #3 obtained a g-tube de-clotter which she threaded through the g-tube unclogging it. The RN then administered Unsampled Resident U's medications and water flushes. Further observation revealed RN #3 did not check the residual in Unsampled Resident U's stomach throughout the procedures to assess how well he/she was tolerating the tube feedings and medications administration; as per the care plan.</p> <p>Interview with RN #3 on 03/07/14 at 4:40 PM, revealed she usually checked for residual prior to the administration of medication and water. She stated she did not know why she had not checked for residual on 03/06/14 prior to administering Resident #18 and Unsampled Resident U's medications.</p> <p>Interview, on 03/17/14 at 5:45 PM, with RN #2/UC, of the unit on which Resident #18 resided, revealed her expectations were for nurses to check for the amount of residual tube feeding in a resident's stomach prior to the administration of any fluid or medication through the g-tube.</p>	F 322			

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F 322 | Continued From page 84
Interview with the DON on 03/08/14 at 2:10 PM revealed it was her expectation for nurses to check for residual before the administration of any fluid or medication through the g-tube. She stated she expected nursing staff to follow each resident's nursing care plans and the facility's policy and procedures related to the administration of medications and fluid through a g-tube, as well as, follow the specific Physician's Orders related to administration of g-tube feeding, and water flushes.

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the facility's policies, Material Safety Data Sheets (MSDS), and the "10 Step Cleaning" document, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as was possible.

Observations during the initial facility tour, beginning 03/04/14 at 10:40 AM, revealed a housekeeping cart was left unsecured and unattended with cleaning chemicals on the cart. Other observations included a wet floor at the main entrance hallway with only one (1) "Wet

F 322

F 323

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

N218 902 KAR 20:300-8(7)(a) Section 8. Quality of Care.
(7)Accidents. The facility shall ensure that: (a)The resident environment remains as free of accident hazards as is possible;

Criteria #1 All potentially dangerous chemicals used by the housekeeping department are kept in the locked compartment of the housekeeping cart when not in use and/or out of the housekeepers sight, as determined by weekly housekeeping rounds performed by the Director of Housekeeping.

-Wet floor signs are utilized to identify freshly mopped areas and to direct traffic to the dry passage area.

-The sinks in rooms #29 and #34 were securely fastened to the wall.

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F 323	Continued From page 85 Floor" warning sign at one (1) end of the hall, heat register vents were covered with personal objects in rooms 25 and 28, and two (2) sinks were loose from the wall in rooms 29 and 34. The findings include: 1. Review of the facility's "Accidents and Supervision Training" document, undated, revealed the facility defined hazards as elements of the residents' environment that had the potential to cause injury. Review of the training document revealed chemicals used in housekeeping were identified as materials that posed a hazard to residents. Continued review of the section under the section on actions to prevent accidents, facility staff were to identify environmental hazards or risks and communicate information about the observed hazards. Review of the facility's, "Hazard Communication Program", undated, revealed a hazardous chemical had been defined as a chemical that was a physical or health hazard. The document listed chemicals which were irritants and a health hazard. Further review revealed chemicals were to be appropriately stored in secured areas at all times. Review of the facility's "Housekeeping Training" document, undated, revealed all housekeeping chemicals were to be locked up when not in use. Observations, on 03/04/14 at 10:40 AM and 10:58 AM, revealed a housekeeping cart outside of a resident's room on the West Hall was unattended. Continued observation revealed the housekeeper was in a resident's room at those times. Further observation revealed chemicals	F 323	-The personal items were removed from the heater units in rooms #25 and #28. Criteria #2 All residents in the area of the housekeeper's cart or in the wet floor area identified during the survey process have the potential to be affected by this alleged deficient practice. -All resident rooms have the potential to be affected by this alleged deficient practice. Criteria #3 The housekeeping orientation checklist has been reviewed/ revised to include storage of potentially dangerous cleaning products, and utilization of wet floor signs to identify freshly mopped areas and to direct traffic to the dry passage area. -All housekeeping staff members have received in-service education on the need to keep all potentially hazardous chemicals in the locked compartment of the housekeeping cart when not in use and/or out of the housekeepers' sight, and on the utilization of wet floor signs to identify freshly mopped areas and to direct traffic to the dry passage area on 3/17/14 and 4/4/14 as provided by the Housekeeping Supervisor. and utilization of wet floor signs to identify freshly mopped areas and to direct traffic to the dry passage area. -All housekeeping staff members have received in-service education on the need to keep all potentially hazardous chemicals in the locked compartment of the housekeeping cart when not in use and/or out of the housekeepers' sight, and on the utilization of wet floor signs to identify freshly mopped areas and to direct traffic to the dry passage area on 3/17/14 and 4/4/14 as provided by the Housekeeping Supervisor		

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F 323 Continued From page 86
on the unsecured housekeeping cart included a bottle of "Bye Bye Odor" and a bottle of "Crew Neutral NA Non-Acid Bowl and Bathroom Disinfectant Cleaner".

Review of the facility's MSDS for the "Bye Bye Odor" product, undated, revealed excessive ingestion could cause nausea or diarrhea. In addition, the product could be an irritant to skin and eyes.

Review of the facility's MSDS for "Crew Neutral NA Non-Acid Bowl and Bathroom Disinfectant Cleaner", dated 08/04/10, revealed if the eyes came into contact with the product, it was moderately irritating to the eyes.

Review of the facility's list of residents at risk for wandering revealed four (4) residents on the West Hall were at risk.

Interview with Housekeeper #2, on 03/04/14 at 11:05 AM, revealed housekeeping chemicals not in use were to be locked up. Continued interview revealed after using the bowl and bathroom disinfectant in a resident's bathroom, she hung the bottle on the housekeeping cart to go in to mop the floors in the rooms. She indicated she should not have left the bottle hanging unattended on the cart. Housekeeper #2 stated she knew housekeeping chemicals were to be locked up all the time when not in use. She stated she was unsure if the "Bye Bye Odor" was supposed to be locked up.

Interview with the Housekeeping Director, on 03/08/14 at 4:45 PM and 5:15 PM, revealed housekeeping chemicals were not to be left out on the cart, and the carts were to be locked and

F 323 accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.

Criteria #4 The CQI Tools are included for Review as Attachments ES-7 and N-26. The CQI Tools address compliance with the entire Regulation, and will be completed monthly X 6 Months and then quarterly thereafter under the Supervision of the Administrator (ES-6) and DON (N-26). Results of the audits will be Reported to the QA Committee by Department Heads monthly for six (6) months and Quarterly thereafter. If an accepted threshold of Compliance, as referenced on the CQI Tool, is Not achieved, the appropriate Department Head Shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Health will face personnel action.

-The facility is also utilizing additional CQI indicator tools for the monitoring of safety issues as identified in the regulation which include: Life Safety; Safety Inspection - Housekeeping; Safety Inspection - Laundry; Safety Inspection - Maintenance; Safety Inspection - Dietary, Safety Inspection - Nursing, and Falls. These are utilized quarterly under the supervision of the department head assigned to the tool, with all findings and follow up completed as identified above.

Criteria #5 April 9, 2014.

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in view anytime the housekeeper left the cart to go clean in residents' rooms. The Housekeeping Director stated it was dangerous to leave housekeeping chemicals unsecured on carts in reach of residents as they could spill the chemicals on themselves, and/or eat and drink them.

Interview with the Director of Nursing (DON), on 03/13/14 at 3:58 PM, revealed it was a safety issue for the housekeeper to leave chemicals unattended on the cart. She stated there were wandering residents who could get the chemicals if left on unattended and unsecured housekeeping carts. The DON further stated the potential for harm was based on the safety hazard listed on the chemicals, and the route of exposure, whether skin or ingestion.

2. Observation of the facility's main entrance lobby area, on 03/06/14 at 11:35 AM, revealed the hallway floor had been mopped and the floor's surface was wet. The Surveyor slipped when stepping on the floor. Continued observation revealed there was a "Wet Floor" sign on only one (1) end of the hallway; however, the housekeeper had mopped the entire floor area of the hallway and left no dry pathway to walk on.

Interview with the Housekeeping Director, on 03/07/14 at 12:41 PM and on 03/08/14 at 4:45 PM, revealed the housekeeper should have: had more signs out indicating the floor was wet; kept the mop as dry as possible; and only mopped one (1) side of the hallway at a time to ensure a dry pathway. Continued interview revealed mopping the whole floor at one (1) time without leaving a dry pathway was a hazard to others, including residents.

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Interview with the DON, on 03/13/14 at 3:58 PM, revealed wet floors were a safety issue related to the potential for falls; however, she stated, the facility only had a couple of residents who ambulated independently.

3. Review of the facility's policy, "Fire and Electrical Safety", undated, revealed heater and air conditioning units were to be free of any items stored on top or in the vicinity of the heating elements. Review of the facility's policy, titled "Safety Policy", revealed lint and trash buildup could cause a fire.

Review of the facility's, "Environmental Services Duty List", undated, revealed equipment in need of repair was to be reported immediately.

Review of the facility's undated "Department Safety Inspection Checklist", which was completed by the Maintenance Department, revealed sinks were an area to be assessed for safety.

Observation during the initial tour of the facility, on 03/04/14 at 10:50 AM, revealed the heater in Room 25 had stuffed animals, a therapy brace and miscellaneous papers lying on top of and covering the heater vent/grate, which impeded air flow. Observation in Room 28 revealed the heater was covered with a large picture frame blocking air flow from the vent/grate. Further observation revealed the bathroom sinks in Room 29 and Room 34 were loose and coming off the wall.

Interview with the Maintenance Director, on 03/07/14 at 12:50 PM, revealed objects were not

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F 323	Continued From page 89 to cover heater vents in the residents' rooms. He stated the staff was aware of this, as he went over it during orientation and on environmental tours with new employees. The Maintenance Director stated safety hazards were to be reported to the Maintenance Department. Continued interview revealed he had not been made aware of the sinks in residents' bathrooms being loose from the wall. He stated staff should have placed the loose sinks in the environmental hazard/work order book that was available at each nurse's station. The Maintenance Director stated if the sinks came off the wall it could cause harm to the resident. Further interview revealed he checked the work order books for concerns and routinely, when time allowed, made rounds of the facility's environment inspecting for maintenance issues. The Maintenance Director stated safety rounds were also performed monthly by the Department Heads, who utilized the Department Safety Inspection Checklist. He stated during those rounds the Department heads looked for issues, such as the loose sinks.	F 323			
F 371 SS=E	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	F 371	F371 FOOD PROCURE, STORE/ PREPARE/ SERVE - SANITARY The facility shall procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. N 283 902 KAR 20:300-10(8)(b) Section 10. Dietary Services. (8)Sanitary conditions. The facility shall; (b) Store, prepare, distribute, and serve food under sanitary conditions;		

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F 371 Continued From page 90
by:
Based on observation, interview, review of the facility's policy and Temperatures of Food Safety Guide, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by cold food temperatures not taken prior to the dinner resident tray line service; and not recorded in the temperature log.

The findings include:

Review of the facility's policy titled "Food Holding Temperatures on Food Service Line" undated, revealed staff was to ensure chilled food and beverages were less than forty-one degrees (41) Fahrenheit to ensure appropriate service temperatures.

Review of the facility's, Temperatures of Food Safety Guide, dated 2009, revealed cold food were to be stored at forty one (41) degrees Fahrenheit or below temperature for storage or display of cold foods.

Review of the facility's food temperature log, dated March 2014, revealed milk as the only cold food temperature which had been checked routinely for lunch and dinner. Continued review of the log revealed a note at the bottom which stated all cold meat or egg entrees were to be maintained at forty (40) degrees Fahrenheit or below because they were potentially hazardous foods.

Observation on 03/04/14 at 5:00 PM, of the resident tray line temperatures revealed the cold foods temperatures had not been taken and not recorded in the temperature log.

F 371

Criteria #1 – The dietary department has a temperature monitoring log for each hot and cold food item (including cake) being served on the tray line for each meal, as determined by completion of CQI tool A-8 on 4/7/14. Food temperature is checked and documented as per facility policy and monitored by the RD weekly.

Criteria #2 – All residents receiving oral nutrition have the potential to be affected by this alleged deficient practice.

- The dietary department has a temperature monitoring log for each hot and cold food item (including cake) being served on the tray line for each meal. Food temperature is checked and documented as per facility, and dietary sanitation was audited utilizing CQI D-8 on 4/7/14 by the RD/DM.

Criteria #3 – The dietary department staff received in-service education on dietary sanitation compliance including but not limited to: keeping a temperature monitoring log for each hot and cold food item (including cake) being served on the tray line for each meal as provided on 4/3/14 by the RD. Food temperature is checked and documented as per facility policy.

Criteria #4 – The CQI Tool is included for review as Attachment D-8. The CQI Tool addresses compliance with the entire regulation, and will be completed monthly under the supervision of the Dietary Manager. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of

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F 371 Continued From page 91

Interview, on 03/04/14 at 5:03 PM, with Dietary Aide #1 revealed she had not taken the temperatures of cold foods; and therefore had not recorded the temperatures of cold food.

Observation, on 03/04/14 at 5:05 PM, of Dietary Aide #1 taking the temperature of the pureed cheesecake as requested which revealed the temperature to be forty-two (42) degrees Fahrenheit.

Interview, on 03/06/14 at 10:20 AM, with the Dietary Manager/Registered Dietitian (DM/RD) revealed cold foods were put into the refrigerator prior to service and milk into the freezer prior to service. The DM/RD stated temperatures of cold food were not taken because the cold foods were kept in the refrigerator or freezer prior to service. He stated foods, such as, cake were shelf stable and temperatures did not need to be checked. Continued interview revealed cold foods higher than forty (40) degrees Fahrenheit needed to be put into the refrigerator or freezer.

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

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

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;

F 371 the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.

Criteria #5 April 9, 2014

F 441 INFECTION CONTROL
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.

N 144 902 KAR 20-3--6(7)(b)2.a.
Section 6. Quality of Life
(7)Environment.
(b)Infection control and communicable diseases.
2.The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility.

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F 441 Continued From page 92

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

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

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection as evidenced by three (3) of twenty-four (24) sampled residents (Residents #17, #19 and #22) and fourteen (14) unsampled residents (Unsampled Residents A, B, C, D, E, F, G, J, K, L, O, Q, R, S) diagnosed with Tinea

F 441

Criteria #1 – All infections for the last 30 days have been reviewed on 3/31/14 and 4/7/14 by the interdisciplinary infection control team to identify any trends or patterns that need to be addressed. Treatments have all been implemented as ordered. Residents #17, 19, and 22 did not have any infections identified upon this review on 3/31/14, and 4/7/14.

-Meal service is provided by all staff utilizing infection control standards of practice for hand sanitation, as determined by meal observations performed by administrative nursing staff performed on 3/31/14, 4/2/14 and 4/7/14

-Resident care/hygiene items are labeled and stored in accordance with infection control standards of practice as determined by weekly. SRNA Room Rounds.

-Peri-care, catheter care, and wound care are provided in accordance with infection control standards of practice as determined by care observations performed by administrative nursing staff on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, and 4/4/14.

Criteria #2 – All residents with infections, receiving assistance with meals, and receiving peri-care, catheter care, and wound care have the potential to be affected by this alleged deficiency.

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F 441 Continued From page 93

Pedis (Athlete's foot) in January 2014 with no documented evidence of an investigation for the root cause; and no documented evidence of infection control interventions to prevent further transmission initiated by the facility.

In addition, review of the facility's monthly data of Urinary Tract Infections (UTIs), a part of the facility's infection surveillance, revealed the November 2013 data had sixteen (16) residents with UTIs; and the South Hall of the West Wing had eight (8) of the UTI total. Further review of the facility's infection surveillance data revealed in January 2014 there had been thirteen (13) UTIs with a cluster of infections on the South Hall of the West Wing which had six (6) of the total UTIs. Further review of the data revealed no infection control corrective measures had been initiated by the facility's infection control program related to the identified infection surveillance data.

Also, observation of care for Resident #8 revealed poor infection control technique by staff related to an indwelling urinary catheter, handwashing, incontinence care, and droplet/transmission control precautions for Resident #8. Observation of a skin assessment for Resident #6 also revealed poor infection control technique by staff.

Also, observations on initial tour revealed bed/wash pans were on the floor and or stored unbagged in multiple resident rooms and bathrooms.

In addition, observations of meal service in the dining room revealed a State Registered Nursing Assistant (SRNA) had been assisting a resident at a restorative table by wiping the resident's

F 441

Criteria #3 -An interdisciplinary infection control team has been established to monitor and review all facility infections and to develop plans of action for any trends, patterns or outbreaks that are identified.

-Facility SRNA staff have received inservice education by the SDC on the need to maintain infection control standards of practice for all resident care, including but not limited to: meal assistance, peri-care, and catheter care on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14 and 4/4/14.

-Facility licensed nurses have received inservice education by the SDC on the provision of all care in accordance with infection control standards of practice received inservice education by the SDC on the provision of all care in accordance with infection control standards of practice including but not limited to wound care, as provided on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14.

-Newly hired SRNA and Licensed staff will receive the education identified above as part of the orientation program, as provided by the SDC.

-General infection control inservicing was performed for housekeeping and dietary on 3/17/14 and 4/8/14.

Criteria #4 -The CQI Tool is included for review as Attachment IC-2. The CQI Tool addresses compliance with the entire regulation, and is completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold

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F 441	Continued From page 94 mouth and assisting the resident to drink fluids; and then without washing or sanitizing her hands moved to another restorative table and started assisting with feeding another resident. The findings include: Review of the facility's policy titled, "Infection Control", undated, revealed it was the policy of the facility to provide a safe, sanitary and comfortable environment. Continued review revealed the facility would investigate, control and attempt to prevent the development and transmission of infections. In addition, the policy stated it was the responsibility of the Continuous Quality Improvement (CQI) Committee to ensure Infection control policies and procedures were implemented and followed. Review of the facility's policy titled, "Infection Control Program", undated, revealed the infection control program would develop prevention, surveillance and control measures to protect residents from institution-acquired infections. Further review revealed the infection control program would perform surveillance activities for monitoring and investigating causes of infection; and the manner of spread in order to prevent infections in the facility. Review revealed the infection control program would analyze clusters of infection and any increase in the rate of infection. 1. Review of the facility's policy titled, "Policy for Outbreak Investigation", undated, revealed it was the facility's policy for outbreak measures to be instituted whenever there was an incidence of infections above what was normally expected. Continued review revealed the Infection Control	F 441	of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action Criteria #5 April 9, 2014.		

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F 441	<p>Continued From page 95</p> <p>Professional conducted outbreak investigations; and had the authority to implement control measures as appropriate in coordination with facility administration and medical staff. In addition, the policy stated appropriate notifications were to have been completed to the Medical Director.</p> <p>Interview, on 03/06/14 at 5:54 PM and on 03/07/14 at 3:09 PM, with the Infection Control Nurse (ICN) revealed the program was to analyze infection clusters in a timely manner; and she defined a cluster as multiple infections of the same type of infection in one area of the building. The ICN revealed she had calculated rates of infection and if the rate had been significantly higher an inservice would have been completed or check-offs for prevention and control of additional cases. She further revealed the point of tracking and trending was to prevent further infections.</p> <p>Interview, on 03/08/14 at 10:41 AM, with the Medical Director revealed a cluster infection determination was based on the following factors: the same type of pathogen; the timing of the infections; and the locations of the infections. Continued interview revealed if a cluster had been identified he and facility staff would discuss and put together an action plan.</p> <p>Review of the facility's infection surveillance data revealed in January 2014 the facility had seventeen (17) cases of Tinea Pedis diagnosed in the facility. Continued review of the data revealed the facility's mapping of infections indicated the location of the Tinea Pedis in the facility were as follows: West Wing North Hall one (1) case; West Wing South Hall five (5)</p>	F 441		

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F 441 Continued From page 96 cases; East Wing South Hall eight (8) cases; and East Wing North Hall three (3) cases.

F 441

Interview, on 03/07/14 at 3:07 PM, with the Podiatrist, who saw residents on 01/07/14 revealed Tinea Pedis was a skin fungal infection which could appear as wet or dry; and might or might not have been irritating to the residents. The Podiatrist revealed it was common in older adults; and could live in nail beds even after treatment and come back. She stated the infection could have been passed from common shower rooms; and preventive measures included disinfecting showers, wearing clean socks and shoes and keeping feet clean and dry.

Continued interview with the ICN on 03/06/14 at 5:54 PM, on 03/07/14 at 3:09 PM and 5:30 PM, revealed the facility had seventeen (17) cases of Tinea Pedis in January of which sixteen (16) had been identified by a new Podiatrist during her visit on 01/07/14; and one (1) case had been diagnosed by the Advanced Practice Registered Nurse (APRN). The ICN stated topical treatment, Terbinafine (antifungal medication), had been ordered. The ICN revealed this had been a significant increase from prior months as no Tinea Pedis infections had been reported from September 2013 to December 2013. The ICN revealed the APRN had been made aware when the antifungal medication orders had been taken off on 01/07/14. She stated the APRN did not think the residents diagnosed with the Tinea Pedis had the condition. She stated she and other facility staff had discussed the Tinea Pedis infections at the 01/13/14 stand-up meeting which included Unit Managers, the Director of Nursing (DON) and Treatment Nurse. According to the ICN, the Medical Director and the facility's Quality

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F 441 Continued From page 97
Assurance (QA) Committee had been notified on 01/15/14. The ICN stated she had made suggestions to the DON to implement infection control measures which included inservicing on preventing the spread of the Tinea Pedis, and ensuring the residents' feet had been washed and moisturized, and their socks changed daily. She stated she was unaware of any action plan having been initiated; however, the infection control process included making attempts to reduce infections if concerns were identified with the data. Continued interview revealed she felt the facility had not put an action plan in place because the Medical Director had not thought the residents had Tinea Pedis. The ICN stated neither the APRN nor the Medical Director were asked to check any of the other residents in the facility.

Interviews, on 03/07/14 at 3:09 PM and on 03/08/14 at 2:22 PM, with the DON revealed if there had been an outbreak of an infection the APRN and Medical Director were notified; and all residents should have been checked for further cases. The DON revealed when the Physician's Orders had been reviewed at the morning meeting on 01/08/14, the Unit Managers were made aware and should have notified the staff of the Tinea Pedis infections. She stated facility staff had talked to the APRN; however, they had not notified the Medical Director until 01/15/14, however should have notified him when the Tinea Pedis had been diagnosed. The DON stated the facility had not done a root cause analysis for the Tinea Pedis infections; had not looked up the Centers for Disease Control (CDC) recommendations; had not put together any action plan; had not had the Medical Director or APRN check all the residents; and had not

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F 441	Continued From page 98 performed any special skin assessments of residents. She stated, however when the Medical Director had been notified he looked at some of the residents diagnosed with the Tinea Pedis and had not thought the residents had the infection. The DON stated the Medical Director had thought the residents just had dry skin on their feet. Interview, on 03/08/14 at 10:25 AM, with the Licensed Practical Nurse (LPN) #9/Unit Coordinator (UC) on the East Hall revealed she or the other UC attended the facility's daily stand up meetings where they discussed information. LPN #9/UC stated she did not recall having been informed of the Tinea Pedis in January; or of any education of staff regarding preventive measures, or need for any skin assessments related to it. She stated she should have been made aware. Interview on 03/07/14 at 4:11 PM, with Registered Nurse (RN) #2/ UC on the West Hall, revealed she had been aware the Podiatrist had written orders related to Tinea Pedis in January, and had talked about whether it was Tinea Pedis or just dry skin. She stated she did not do any education with staff regarding the Tinea Pedis. Interviews with RN #5, on 03/07/14 at 2:56 PM, and LPN #9, on 03/07/14 at 2:58 PM, revealed they had not recently been inserviced on Tinea Pedis infections. Interviews on 03/08/14 at 10:00 AM, 10:05 AM, and 10:15 AM, with the Housekeeping Director, Housekeeper #1 and Housekeeper #2, revealed they had not been informed of any infections, including Tinea Pedis, or of any special precautions necessary.	F 441			

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F 441	<p>Continued From page 99</p> <p>Continued interview with the Medical Director, on 03/08/14 at 10:41 AM, revealed the Tinea Pedis cases had been discussed at the QA Committee meeting. He stated he had not been aware of any additional infection control measures and had not followed up with each of the residents diagnosed. The Medical Director further stated he felt the root cause had been dry feet and an "overzealous" Podiatrist, because dry skin could look like Tinea Pedis. Continued interview revealed the facility had no cases of Tinea Pedis identified the prior three months by other Podiatrists who had seen residents at the facility. He stated if it had been Tinea Pedis, generally only one third of the infections would have resolved when treated topically and he was not been aware of any repeat signs or symptoms in the following months. The Medical Director stated the Podiatrist who visited the facility in January had not done a culture for a definitive diagnosis; however, the facility had not altered the treatment plan ordered because topically applying the antifungal cream had not been a "bad idea" and would not have had a negative impact on the residents. The Medical Director further stated he felt he had been notified in a timely manner by the facility.</p> <p>2. Further review of the monthly infection control surveillance data revealed the facility had sixteen (16) UTIs in November 2013. Review of the facility's surveillance map revealed eight (8) of the residents diagnosed with UTIs had been on the South Hall of the West Wing. Continued review of the data revealed the dates the infections were identified were: three (3) on 11/02/13, one (1) on 11/13/13, one (1) on 11/15/13, two (2) on 11/18/13, and one (1) on 11/22/13. Further review of the data revealed the West Wing North</p>	F 441		
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F 441	<p>Continued From page 100</p> <p>Hall and the East Wing South Hall each had three (3) infections; and the East Wing North Hall had two (2) infections. Of the eight (8) infections on the West Wing South Hall, five (5) were cultured to be Escherichia Coli (e-coli). Review of the December 2013 UTI data revealed six (6) UTIs were reported.</p> <p>Additional review of the monthly surveillance data for January revealed thirteen (13) UTIs were diagnosed. Review of the surveillance map revealed the West Wing South Hall had six (6) infections; with the infection identification dates as follows: one (1) on 01/14/14, four (4) on 01/15/14, and one (1) on 01/29/14. Continued review of the surveillance map revealed the East Wing North Hall had four (4) infections and the West Wing North Hall had three (3).</p> <p>Continued interviews with the ICN, on 03/06/14 at 5:54 PM and on 03/08/13 at 11:40 AM, revealed she would have considered the West Wing South Hall in November and January totals to have been a cluster of infections because they occurred in the same period of time, and were grouped in the same area of the facility. She stated the January UTI total had been a concern because it doubled the prior month's total, and the infection rate had been thirteen percent (13 %). She stated the facility normally had an average rate between seven percent (7%) and ten percent (10%). She revealed she was not aware of any type of action plan put in place after she reported the November and January data. She further stated she also presented the data to the QA Committee.</p> <p>Review of Inservice Education revealed no documented evidence of recent education on</p>	F 441		
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F 441	<p>Continued From page 101</p> <p>UTIs or prevention of them. Continued review revealed the last documented inservice on "UTIs and Prevention" was on 06/28/13.</p> <p>Interview with the Staff Development Coordinator (SDC), on 03/08/14 at 4:27 PM, revealed the facility had no documented evidence of any special inservices performed after the November UTI surveillance data was reported; however, she stated there should have been an inservice with that number of infections. The SDC stated the last catheter care inservice had been in October 2013. She stated the facility performed catheter care and perineal care checkoffs annually and she tried to observe one hundred percent (100%) of the State Registered Nursing Assistants (SRNAs). The SDC also reported SRNAs had received annual training via the computer related to catheter care and perineal care. Continued interview revealed the facility had no process in place to perform random audits of perineal care when the facility identified a high number of UTIs.</p> <p>Interview on 03/13/14 at 10:16 AM, with LPN #9/East Wing UC, revealed she periodically received a check off list and observed an SRNA performing Foley catheter care and perineal care. She stated the last time she had done this was sometime before December, when she had observed five (5) SRNAs providing the care.</p> <p>Interviews, on 03/13/14 at 9:39 AM with SRNA #13, at 9:48 AM with SRNA #17, and at 10:11 AM with SRNA #14 revealed they all indicated it had been a while since they had received any inservices on indwelling catheter care or perineal care, and the only recent training had been on the computer. SRNA #13 stated it had been a while since someone observed her to provide perineal</p>	F 441		
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F 441	<p>Continued From page 102</p> <p>care or catheter care. SRNA #14 was unable to recall anyone ever watched her perform catheter care. SRNA # 17 reported she thought she was observed by a nurse, during the month of February, while she had been providing the care.</p> <p>Interview with the DON, on 03/07/14 at 3:09 PM and on 03/08/14 at 2:22 PM, revealed when concerns related to UTIs were identified, the facility needed to do inservices for staff regarding proper perineal care and handwashing. She stated she thought the facility provided inservices on perineal care, catheter care and handwashing after the seventeen (17) UTI's were reported in November; however, she stated she was unable to locate documented evidence of the training. The DON stated the January UTI infections on the West Wing South Hall could have been considered a cluster, and the facility should have followed up more closely with inservices on hand hygiene, perineal care and catheter care. In addition, she stated the facility had not performed any monitoring through observations of staff providing perineal care or catheter care.</p> <p>3. Review of the facility's policy, titled "Perineal/Catheter Care Protocol", undated, revealed staff were to wash their hands prior to providing the care and after cleaning the pubis and penis. Continued review revealed if a catheter was in place, staff were to obtain a new wash cloth and cleanse the catheter well, beginning at the insertion site and moving away from the body, and use a clean wash cloth to rinse the catheter. Further review revealed after the perineal care was completed, staff were to remove their gloves, wash their hands, and don a clean pair of gloves to apply the resident's brief.</p>	F 441		

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F 441 Continued From page 103

Review of the facility's policy, titled "Procedure for Handwashing-Nursing", undated, revealed staff were to wash their hands after handling any contaminated items and after they touching a resident or the resident's belongings. In addition, the policy stated after staff dried their hands, they were to discard the paper towel into the appropriate container.

a) Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/13 with diagnoses which included Chronic Kidney Disease, Diabetes and a history of UTIs. Continued review revealed Resident #8 experienced a hospitalization and the facility re-admitted the resident on 02/26/14, with additional diagnoses including Acinetobacter (gram-negative bacteria) Pneumonia, Hematuria (blood in the urine), and Urinary Retention (inability to completely or partially empty the bladder). Review of the Quarterly Minimum Data Set (MDS), dated 01/23/14, revealed the facility assessed the resident to be incontinent of bowel and dependent on staff for completion of his/her Activities of Daily Living (ADLs). Further review of the medical record revealed Resident #8's March 2014 monthly Physician's Orders included an order for an indwelling catheter and an order for droplet precautions (required the use of personal protective equipment, such as a facemask, and gloves, gown and goggles/face shield if substantial spraying of respiratory fluids was anticipated).

Observation, on 03/05/14 at 11:10 AM, revealed signage outside Resident #8's door indicating the resident had been placed on droplet precautions. Personal Protective Equipment (PPE) which included gowns, gloves, masks, shoe booties,

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and hand sanitizer was stored for use by staff on a table outside of the room. Continued observation revealed the Wound Treatment Nurse (WTN) donned PPE prior to entering Resident #8's room to complete his/her skin assessment. She washed her hands, then opened the lid of the biohazard trash container with her bare hands to dispose of the paper towel prior to donning her gloves. Resident #8 requested water, and the WTN removed her PPE, obtained the water and donned new PPE prior to entering the room. The WTN again was observed to wash her hands and open the biohazard trash container with her bare hands to dispose of the paper towel prior to donning her gloves. Continued observation revealed Resident #8 was soiled with bowel movement during the skin assessment and LPN #8 and SRNA #19 entered the room to provide assistance. LPN #8 entered the room without gloves, then donned gloves without washing her hands. After donning the gloves, LPN #8 touched areas of the room with her gloved hands. SRNA #19 entered the room with gloves already on and was not observed to have washed her hands prior to providing care. LPN #8 tied the SRNA's gown with her gloved hands. LPN #8 assisted the WTN to reposition the resident so SRNA #19 could cleanse the resident's buttocks and anal area. After completion of resident care and the skin assessment, LPN #8 removed her PPE; without washing or sanitizing her hands, she opened the door and reached outside the room to obtain the hand sanitizer from the PPE table in order to cleanse her hands before leaving the room. In addition, during the performance of bowel care, SRNA #19 placed the closed soiled brief on the resident's bed and soiled wash cloths on top of the brief. After cleansing the resident,

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F 441	<p>Continued From page 105</p> <p>SRNA #19 did not wash or sanitize her hands prior to obtaining a new brief.</p> <p>Interview, on 03/06/14 at 4:12 PM, with the WTN revealed typically there was a waste paper basket in the bathroom to dispose of paper towels in. She stated since there had been no waste paper basket in Resident #8's bathroom, she had used the biohazard container to dispose of the paper towels prior to putting on her gloves. She further stated the biohazard container which she had touched after washing her hands was potentially contaminated and she should not have touched it. Continued interview revealed the SRNA should have had two (2) separate plastic bags to put the brief and linens in when she performed the bowel care, and should not have put the soiled brief and towels on the bed linens due to the potential for contamination.</p> <p>Interview with LPN #8, on 03/08/14 at 5:55 PM, revealed after providing care she did not go into the bathroom to wash her hands because she had already taken off the PPE, so she just reached out the door and grabbed the hand sanitizer. She stated after she left the room, she went to the medication room and performed hand hygiene. Continued interview revealed she knew her hands she was supposed to have washed her hands prior to leaving the room.</p> <p>Interview with SRNA #19, on 03/08/14 at 5:36 PM, revealed she did not wash her hands upon entering Resident #8's room because she had washed her hands prior to leaving another resident's room, and she had applied PPE and gloves prior to entering Resident #8's room. She stated she was supposed to wash her hands when entering the room, but she had been</p>	F 441		
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rushing. Continued interview revealed she was not supposed to put a soiled brief on the bed or soiled linens on the brief, because of infection control; however, she had not had any plastic bags to put them in. SRNA #19 indicated she had not realized the nurse had touched items in the environment before she tied the aide's gown. She further indicated it could have been looked at as an infection control issue.

Interview with the SDC, on 03/06/14 at 3:29 AM, revealed staff had been trained to their wash hands and don their gloves in the room. She stated SRNA #19's gown should have been in place and tied prior to entering Resident #8's room. Continued interview revealed when staff performed incontinence care they should have a bag at the bedside for soiled briefs and soiled linens. The SDC stated when SRNA #19 finished the bowel incontinence care, she should have washed her hands prior to obtaining and applying the new brief. She further stated the opportunity for staff to have used transmission precautions, such as droplet precautions, had not occurred routinely. She revealed she had not done any staff re-education after the resident was placed on the precautions, and prior to allowing staff to care for Resident #8. She stated there could be breaks in infection control technique if staff were not familiar with using transmission precautions.

Interview with the ICN, on 03/06/14 at 5:54 PM, revealed the staff should have washed their hands once they entered Resident #8's room and not prior to entering the room. She stated after LPN #3 washed her hands, she should not have touched the biohazard container lid with her bare hands. The ICN further stated at the point the nurse touched the biohazard container lid her

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hands would be considered contaminated. According to the ICN, LPN #8 should have washed her hands prior to exiting Resident #8's room, and should not have used the hand sanitizer stored outside the door as it could have been contaminated with a micro-organism. The ICN revealed supervisors performed audits on handwashing and the data was reported to the DON, but she had not reviewed the data. Continued interview revealed SRNA #19 should have placed Resident #8's soiled brief and wash cloths in trash bags, because placing them on the bed could have contaminated the bed with organisms. She further stated the Unit Managers monitored PPE use by staff and she had not heard of any issues related to this. She explained staff should have had their PPE in place prior to entering the room, to prevent contaminating their own clothing.

b) Observation of urinary catheter care by SRNA #14, on 03/07/14 at 10:08 AM, revealed she washed the resident's groin and penis area with a wash cloth, and used the same wash cloth to clean the catheter. Continued observation revealed SRNA #14 performed the same process when rinsing the areas.

Interview with SRNA #14, on 03/07/14 at 10:08 AM, revealed she had been trained in providing catheter care. She stated after she had washed the residents groin and penis areas, she should have obtained and used a new wash cloth to cleanse the catheter. She further stated she should have followed the same process when she rinsed the area and the catheter.

Interview with the ICN, on 03/06/14 at 5:54 PM, revealed when cleaning the urinary indwelling

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F 441	<p>Continued From page 108</p> <p>catheter the facility's expectation was for staff to ensure a clean wash cloth was used. She indicated potentially harmful organisms could have been transmitted from the penis and groin areas to the catheter with a potential for causing the resident to have a UTI.</p> <p>Interview with the DON, on 03/08/14 at 2:22 PM, revealed the issues identified related to handwashing, skin assessments, perineal care and catheter care were an infection control concern due to the possibility of transferring potentially harmful organisms. She further stated the facility had not conducted ongoing audits of perineal care, catheter care or handwashing and the current role of the ICN had been to track and trend infections only.</p> <p>4. Observation of Resident #6's skin assessment, performed by LPN #2 on 03/05/14 at 10:20 AM, revealed the nurse touched the resident's buttocks during the assessment. Without washing or sanitizing her hands, she proceeded assessed the resident's vaginal area.</p> <p>Interview on 03/05/14 at 10:35 AM with LPN #2, she had not realized she needed to had washed or sanitized her hands after assessing the resident's buttocks; and prior to assessing the resident's vaginal area.</p> <p>During interview, on 03/06/14 at 5:54 PM and on 3/11/14 at 2:00 PM, the ICN revealed LPN #2 should have assessed the resident's perineal area prior to the buttocks to prevent cross contamination.</p> <p>5. Observations on 03/04/14 starting at 10:00 AM, during the initial tour of the facility, revealed bed</p>	F 441		

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F 441	Continued From page 109 pans or wash basins were uncovered and lying on the floors of the rooms or bathrooms in rooms 21, 23, 24, 27, 37, and 57. In addition, toothbrushes were observed lying uncovered on the bathroom sinks for rooms 8 and 28. Interview on 03/04/14 at 11:18 AM with RN #2/UC of the West Wing, revealed toothbrushes should not have been lying uncovered on the sink; they should have been in a toothbrush holder or plastic bag and labeled with the residents' names. She further stated having the toothbrushes lying on the sink had been an infection control issue. Interview with the ICN, on 03/06/14 at 5:54 PM, revealed bed pans and wash basins should not have been left on lying on the floor uncovered, as it was an infection control concern. She stated they should have been placed in bags and labeled with the residents' names. She further stated the practice of leaving toothbrushes uncovered on the sinks increased the risk of cross contamination and infection. Interview with the DON, on 03/08/14 at 2:22 PM, revealed the Unit Managers performed environmental rounds looking for issues such as unlabeled and unbagged wash basins and bedpans in residents' rooms. She stated if the Unit Managers observed those items stored in that manner they were to ensure they were bagged and labeled. The DON revealed this was an ongoing problem in the facility and the SDC was training during orientation and re-education of staff. She stated the concern was the potential for the spread of infection. 6. Observation of the lunch meal, on 03/04/14 at 12:45 PM, revealed SRNA #20 assisted	F 441			

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F 441	Continued From page 110 Unsamped Resident M by wiping his/her mouth with a clothing protector and giving the resident a drink of fluids at the restorative table. Continued observation revealed the SRNA moved to the next restorative table without washing or sanitizing her hands, and assisted with feeding Unsamped Resident N. Interview with SRNA #20, on 03/08/14 at 2:22 PM, revealed she had not received any training on infection control related to feeding two (2) residents. Interview with the SDC, on 03/08/14 at 4:27 PM, revealed the facility had nurses circulate in the dining room during meal service to observe for any infection control issues; however, sometimes the nurses had to assist with feeding residents and could not observe the whole dining area. She stated SRNA #20 should not have moved from resident to another without washing or sanitizing her hands because of the potential for cross contamination.	F 441			
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of	F 464	Requirements for Dining & Activity Rooms. The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted, be well ventilated, with nonsmoking areas identified, be adequately furnished, and have sufficient space to accommodate all activities.		

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F 464 Continued From page 111
the facility's policy, it was determined the facility failed to provide sufficient space in the dining room to accommodate residents for one (1) of twenty-four (24) sampled Residents. Resident #5 was unable to exit the dining room in his/her wheelchair, without staff assistance. In addition, two (2) unsampled residents seated at adjacent tables were so crowded their assistive devices touched at times.

The findings include:

Review of the facility's policy, titled "Assistance with Meals", undated, revealed residents were to receive assistance with meals in a manner which met their individual needs. Continued review revealed dining room residents who required assistance were to be fed with attention to safety, comfort and dignity.

Observation of the lunch meal service in the main dining room, on 03/04/14 at 12:53 PM, revealed Resident #5 was seated in a wheelchair on the side of a table next to the wall. Due to crowding, the resident was unable to exit independently from the table area and required assistance from staff.

Interview with the Staff Development Coordinator(SDC), on 03/08/14 at 4:27 PM, revealed due to spacing issues all residents could not be in the dining room at one time. She stated she had noticed Resident #5's inability to to exit from the table on 03/04/14. She stated since that time, staff had moved the resident's location in the dining room to better accommodate him/her.

Subsequent observation of the meal service, on 03/04/14 at 1:11 PM, revealed the two (2) middle

F 464 N 074 902 KAR 20:310-7(4)(a) Section 7. Nursing Unit(4)Patient's dining, TV viewing and recreation areas. (a) The total areas set aside for these purposes shall be not less than thirty (30) square feet per bed for the first fifty (50)beds and twenty (20) square feet per bed for all beds in excess of fifty.

Criteria #1 - Residents eating in the dining room are provided more space by the implementation of 2 additional dining areas for meal service. Resident #5 is able to maneuver the wheelchair without obstructions with the additional space provided by the additional dining areas added on 4/7/14.

Criteria #2 -- All residents utilizing the dining room for meals had the potential to be affected by this alleged deficiency, as determined by the dining audit completed on 4/7/14.

Criteria #3 - Dining service was reviewed by the IDT with the implementation of 2 additional dining areas for each meal to provide more space for each resident. All staff have received inservice education on the new meal service areas as provided by the SDC and Dietary Service Manager on 4/7/14 and 4/8/14.

Criteria #4 -The CQI Tool is included for review as Attachment D-6. The CQI Tool addresses compliance with the entire regulation, and will be completed monthly X 6 months and then quarterly thereafter under the supervision of the Dietary Manager. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter.

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F 464 Continued From page 112

restorative dining room tables were so close together the residents seated at the adjacent table ends, one (1) in a tip back wheelchair and the other in a geri-chair (assistive devices), were crowded so that their assistive devices touched at times.

Continued interview with the SDC, on 03/08/14 at 4:27 PM, revealed the two (2) middle tables in the dining room were for residents who required partial or total assistance with feeding to complete their meals. She stated the residents' assistive devices should not have been touching as that could be considered a dignity issue with the residents' dining experience, as well as a safety or infection control issue.

Interview with the Restorative RN, on 03/08/14 at 5:14 PM, revealed she observed the lunch meal service daily Monday through Friday. She stated sometimes the center tables were too close because housekeeping pushed them together when cleaning. She stated staff tried to seat residents at the ends of the table who were unable to sit straight up and required wheelchairs or geri-chairs. She further stated the chairs should not have been touching because of infection control and safety concerns.

Interview with the DON, on 03/08/14 at 5:45 PM, revealed the facility had recently "revamped" the dining room because they had too many residents who required being fed by staff in the facility, so they were bringing all those residents into the dining room at once to in order to feed them first. Continued interview revealed the residents' chairs should not have been touching. She stated it was a safety concern because they could become tangled.

F 464

If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.

Criteria #5 4/9/2014.

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F 465 483.70(h)
SS=D SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy and "10 Step Cleaning" document, it was determined the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Observations during the initial facility tour, beginning 03/04/14 at 10:40 AM, revealed the ceiling vent and fan in the soiled utility room on the West Hall were covered with an excessive amount of dust.

The findings include:

Review of the facility's policy, titled "Safety Policy", revealed lint and trash buildup could cause a fire.

Review of the facility's, "10 Step Cleaning" document, undated, revealed housekeeping staff were to "high" dust all surfaces above the shoulder.

Observation during the initial tour of the facility, on 03/04/14 at 10:50 AM, revealed the ceiling fan and the exhaust fan in the West Hall soiled utility room had excessive dust buildup on them.

F 465 F465 Safe/Functional/Sanitary/ Comfortable Environment
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Criteria #1-The ceiling vent and fan in the soiled utility room on the West Hall were cleaned by housekeeping.

Criteria #2-An inspection of all Ceiling vents and fans was completed as part of a general housekeeping inspection by the Housekeeping Supervisor and designated Housekeeping staff with cleaning completed with dust build up.

Criteria #3-Housekeeping staff have received inservice education by the Housekeeping Supervisor on 4/18/14 on the need to provide a safe, functional, sanitary, and comfortable environment, including but not limited to inspect and clean all ceiling vents and fans as part of daily cleaning routines.

Criteria #4-The CQI Tool is included for Review as Attachment ES-1. The CQI Tool addresses compliance with the entire regulation, and will be completed monthly X 6 months and then quarterly thereafter under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective

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F 465 Continued From page 114
Interview with the Housekeeping Director, on 03/07/14 at 12:41 PM, revealed the staff was to high dust all fans and vents every Wednesday. The Housekeeping Director stated there should not be more than a week's worth of dust on the fans. He acknowledged there was more than a week's worth of dust on the fans in the West Hall soiled utility room which could be a hazard.

F 465 plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.

Criteria #5 April 9, 2014

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

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

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

N 316 902 KAR 20:300-15 Section 15.
Administration
A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the for three (3) of twenty-four (24) sampled residents (Resident #15 #12 and #1).

Criteria 1: -The DON and NHA received education by the Nurse Consultant on 3/5/14 regarding the regulatory requirements on reporting and investigating allegations of abuse and the elements of a thorough investigation.

State Registered Nursing Assistant (SRNA) #2, on 02/25/14 at approximately 10:30 PM, notified Registered Nurse (RN) #1, that five (5) days earlier on 02/20/14, she had witnessed SRNA #1 verbally abuse Resident #15 and Resident #12; and witnessed SRNA #1 being physically abusive to Resident #1. The facility's Administration failed to ensure Resident #1 was assessed for injury after the facility became aware of the physical allegation. As a result of SRNA #2's delay in reporting these allegations, SRNA #1 was not removed from care of residents and worked on

Criteria 2: -Residents previously interviewed have been interviewed again with additional questions by the DON, NHA and/or the SSD on 3/6/14.

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F 490 Continued From page 115
02/20/14 and 02/21/14.

Although the facility's Administration was notified on 02/25/14, of the alleged abuse which occurred on 02/20/14, SRNA #1 was allowed to report to work and care for residents on 02/26/14 from 3:00 PM to 3:30 PM before being suspended. Therefore, the facility's Administration failed to ensure residents were protected from potential abuse during the investigation.

Also, interview and record review revealed the facility's Administration failed to immediately investigate the allegations; and failed to report all the allegations immediately to State Agencies as per state law. The facility's Administration failed to conduct a comprehensive investigation by only interviewing residents who were interviewable; and not including interviews with staff who had worked at the time of the allegations. Additionally, the facility's Administration failed to ensure a written statement was obtained from SRNA #1, the alleged perpetrator, as per policy.

The facility's Administration also failed to ensure re-education of the facility's abuse policies was provided to the staff involved and to other staff after being notified of the allegations on 02/25/14 to ensure the policies were implemented in the future. (Refer to F-225, F-226, and F-520).

The facility's Administration's failure to have an effective system in place to ensure the facility's policies were implemented; and, failure to ensure its resources were utilized effectively and efficiently was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 03/05/14, and was determined to exist on 02/20/14.

F 490

Criteria 3: -The DON, NHA and SSD received in-service education on the investigation and reporting of abuse by the contracted Nurse Consultant on 3/6/14, including, but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; protection of the resident; and reporting of allegations and findings. Competency was determined by verbalizing understanding and answering questions.

-The NHA shall be responsible for delegating duties to ensure employee compliance with the facility's Abuse Policy; including, but not limited to protecting the resident(s), and reporting allegations and investigation findings to the OIG.

Criteria 4: -All reported allegations will be reviewed by the facility investigation team including the NHA, SSD, and DON immediately during normal business hours to determine which team members will investigate and report the allegation to the required authorities. During off hours, staff shall notify the DON and/or NHA immediately via phone; and the DON and/or NHA shall determine who shall investigate and report.

-The NHA will report all findings of the facility investigation team to the Nurse Consultant upon conclusion of the team review (within 5 working days of the allegation) to determine that all necessary investigation and reporting interventions have been initiated.

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F 490	Continued From page 116 The facility provided an acceptable Credible Allegation of Compliance (AOC) on 03/12/14 with the facility alleging removal of the Immediate Jeopardy on 03/07/14. The Immediate Jeopardy was verified to be removed on 03/07/14, prior to exiting the facility on 03/13/14, with remaining non-compliance at 42 CFR 483.75, Administration, F-490 Administration, with a Scope and Severity of an "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance Committee continues to monitor to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, "Policy on Abuse", undated, revealed all personnel were to immediately report any incident or suspected incidents of resident abuse to their Supervisor, Social Services (SS), the Director of Nursing (DON) and Administrator. Continued review revealed an incident report form was to be initiated by the Charge Nurse upon receiving a report of suspected abuse. Review of the Policy revealed the Administrator, DON and SS Director were to conduct an immediate investigation of abuse or neglect allegations. The Policy further stated the Administrator, DON and/or SS Director were to report incident/allegation to the appropriate State Agencies. Additionally, the Policy indicated written statements were to be obtained from all persons with knowledge of the reported incident. Review of the facility's investigation, "Combined Incident Report/Final Report" form submitted to the State Agencies on 02/28/14 at 5:39 PM,	F 490	-The facility QA team with the Medical Director convened on 03/6/14 to review the circumstances of the allegation, and all interventions which have been and will be implemented by the facility. The CQI Tools are included for review as Attachments A-5 and A-8 (weekly X 4 weeks than as described). The CQI Tools address compliance with the entire regulation and will be completed monthly X 6 months and then quarterly thereafter under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action. - Facility staff will complete a questionnaire at the completion of quarterly training on abuse, neglect, exploitation and misappropriation as provided by the SDC. Any areas of concern and/or problems will be immediately addressed by the SDC SDC will take results of the completed questionnaires auditing and any necessary interventions to the QA committee quarterly. Criteria 5: April 9, 2014.		

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F 490	Continued From page 117 revealed the form listed the "incident date" as 02/26/14, instead of 02/20/14 as per report of SRNA #2. Review of the form revealed SRNA #2 was working the same rooms as SRNA #1 and felt SRNA #1's conversation with the residents involved was not "appropriate". Continued review revealed the shift was over when this was reported to the House Supervisor. Review revealed the House Supervisor reported this information to the Administrator; and SRNA #1 was "suspended" for three days "immediately" to protect the residents. According to the form, the DON and the Social Worker (SW) interviewed the two (2) residents and they indicated no staff member had said or done anything to them that they felt was inappropriate. Review of the form revealed SRNA #2 and the House Supervisor, Registered Nurse (RN) #1, were friends and RN #1 had "had words" with SRNA #1 before. The form stated the facility's conclusion was to return SRNA #1 to work on the day shift and on the other unit to monitor her closely and to offer training in proper technique provided by the Staff Development Director. Further review of the form, revealed no documented evidence of the allegation of physical abuse of Resident #1. However, on 03/05/14 at 10:30 AM, per the request of the Surveyor, for a copy of the completed investigation, a copy of SRNA #2's written statement was received which indicated the alleged physical abuse regarding Resident #1. Interview with SRNA #2, on 03/05/14 at 3:30 PM, revealed on 02/20/14 she had witnessed SRNA#1 being verbally abusive to Resident #15 and Resident #12; and physically abusive to Resident #1. SRNA #2 stated she did not report the abuse until 02/25/14, when she told Registered Nurse	F 490			

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F 490 Continued From page 118

(RN) #1 about the allegations. SRNA #2 explained she had received abuse training on hire and knew she was to report any abuse immediately; however, she had failed to report the abuse. Further interview revealed RN #1 had ensured SRNA #2 notified the DON immediately of the allegations.

Interview with RN #1, on 03/05/14 at 3:50 PM, revealed she immediately called the DON on 02/25/14, after SRNA #2 notified her of the allegations. According to RN #1, the DON informed her she would notify the Administrator.

Interview with the DON, on 03/05/14 at 10:30 AM and 6:30 PM; and 03/07/14 at 12:50 PM, revealed she was notified on 02/25/14 at 10:30 PM by RN #1 and SRNA #2 of the verbal abuse allegations; however, she was not notified of the physical abuse allegation at that time. The DON stated she was unaware of the physical abuse allegation until 02/27/14 when she read SRNA #2's written statement. She stated the investigation was not started until 02/27/14 after she and the SS Director returned from a conference, two (2) days after learning of the allegations. According to the DON, the facility's investigation consisted of interviewing interviewable residents and this did not identify any concerns. The DON stated none of the staff who worked the evening of 02/20/14 was interviewed. She stated there had been a conflict between SRNA #1 and RN #1 and because of that, and the residents expressing no concerns, the facility unsubstantiated the allegations. She indicated she was unaware the facility had not been in compliance with reporting the alleged abuse to State Agencies. The DON stated she thought the facility had five (5) days to report to the State Agencies from the time facility

F 490