

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

PRINTED: 05/29/2015  
FORM APPROVE  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/14/2015
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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 323	Continued From page 94 counter, which was a concern.	F 323		
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Review of the Barbicide Material Safety Data Sheet (MSDS) revealed the product was to be kept out of reach of children and ingestion or eye contact were to be avoided. Review of the MSDS revealed if the product was ingested to drink water and if large quantities were ingested it could cause circulatory shock and medical attention should be sought immediately. Continued review of the MSDS revealed prolonged inhalation of the product could cause disorientation, dizziness or nausea. Further review revealed if the product came into contact with the eyes it could cause a burning sensation, watering or redness.

Interview with contract Beautician #1, on 04/28/15 at 11:20 AM and at 12:43 PM revealed she just closed the door and did not lock it when she left the Salon. She revealed she was not sure whether the Salon door was to be locked if the area was left unattended. She stated she was also not aware she couldn't leave a resident sitting in the Salon unattended, and was unaware the Salon door was supposed to be locked when the Salon was left unattended. Continued interview revealed she had not received any training from the facility on ensuring she kept the Salon door locked if it was unattended, with or without a resident present in it. According to Beautician #1, however, the Barbicide was a chemical which she thought would be "dangerous" if swallowed.

Interview with contract Beautician #2, on 04/29/15, at 2:30 PM revealed she was unaware she couldn't leave a resident sitting unattended in the Salon. Per interview, she was not aware the

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F 323 Continued From page 95  
Salon door needed to be locked when the Salon was unattended, while she went to get residents to bring to the Salon. Further interview revealed she had not received any training from the facility on ensuring the Salon door was locked when it was unattended and not to leave a resident unattended in the Salon.

Interview with the Administrator, on 04/28/15, at 2:20 PM, revealed the Salon service was contracted. He revealed he was unaware the facility had a responsibility to educate the beauticians working in the Salon. Continued interview revealed he was under the impression the beautician license indicated they were familiar with Salon safety in a Long Term Care facility.

F 323

F 353 SS=E 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed

F 353 F 353 E

**Residents Affected**  
Resident #15 is receiving his showers as care planned; and as of 6-8-15 shower sheets are being completed and turned into the DON to verify whether he accepted his scheduled showers or refused them.

Resident #22 call lights on 3-11 are being answered promptly and social services is following up on assuring resolution of her concerns of call lights not being answered promptly on the 3-11 shift.

Resident #A call lights on 3-11 are being answered promptly and social services is following up on assuring resolution of her concerns of call light not being answered promptly on the 3-11 shift.

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OMB NO. 0938-03

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F 353 Continued From page 96  
nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure sufficient nursing staff to attain the highest practicable physical, mental, and psychosocial well-being of each resident for two (2) of twenty-two (22) sampled residents (Residents #15 and #22) and four (4) of six (6) unsampled residents (Unsampled Residents A, B, C and D).

Interviews with Resident #15 and Unsampled Residents B, C and D revealed showers/baths weren't provided on a timely and regular basis. Also, interview with Resident #22 and Unsampled Residents A and B revealed they had to wait an extended period of time on second shift for staff to respond to their call lights.

The findings include:

Review of the facility's, "Staffing Policy and Procedure Direct Care", undated, revealed the facility would actively pursue efforts to provide sufficient staff and sufficient hours of work for the purpose of providing appropriate care to the residents which enhanced the quality of life of each resident. Further review revealed staffing was to be adjusted based on resident care requirements.

Review of the facility's documentation revealed

F 353 Resident #B call lights on 3-11 are being answered promptly and social services is following up on assuring resolution of her concerns of call light not being answered promptly on the 3-11 shift.

Resident #C is receiving her showers as care planned; and as of 6-8-15 shower sheets are being completed and turned into the DON to verify whether she accepted her scheduled showers or refused them.

Resident #D is receiving her showers as care planned; and as of 6-8-15 shower sheets are being completed and turned into the DON to verify whether she accepted her scheduled showers or refused them.

The facility verified that resident #15 resident # C, and # D were receiving their scheduled showers by obtaining the shower sheets from the SRNA after exit on 5-14-15.

The facility verified that the call lights were being answered timely for Resident # 22, # A and # B by conducting resident visits weekly by the Social Services Director and the Administrator after exit on 5-14-15.

**Identification of Other Residents**

All residents have the potential to be affected.

As of 6-8-15 shower sheets are being completed and turned into the DON to match the shower schedule to verify that all showers are being given as scheduled.

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F 353	<p>Continued From page 97</p> <p>fifty-nine (59) of the one hundred and four (104) residents currently in the facility required an assist of two (2) for toileting and transfers, and forty-four (44) residents required an assist of two (2) for turning.</p> <p>1. Record review revealed the facility admitted Resident #22 on 08/26/14 and re-admitted him/her on 09/30/14, with diagnoses which included Cerebrovascular Accident (CVA with Right Sided Hemiplegia (Paralysis), Heart Failure, Diabetes and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/27/15, revealed the facility assessed Resident #22 as cognitively intact, and to require extensive assistance of two (2) staff for toileting. Review of Resident 22's Comprehensive Care Plan revealed a care plan for altered urinary elimination which noted the resident required assistance with toileting related to being incontinent of bowel and bladder. Review of the care plan interventions revealed staff were to provide adult incontinence briefs/pull-ups as needed and provide assistance with toileting. Further review of the Comprehensive Care Plan revealed Resident #22 was at risk for impaired skin related to his/her incontinence and the interventions included to ensure the resident's skin was clean with no excessive moisture.</p> <p>Interview, on 05/02/15 at 8:25 AM, with Resident #22 revealed the resident was able to alert staff when needing to go to the bathroom, and he/she used a bed pan and urinal, wore briefs and needed staff's assistance with toileting. Resident #22 stated when he/she used the call light he/she expected it to be answered timely. However, Resident #22 revealed on the facility's second</p>	F 353	<p>The nursing department including RN's, LPN's, CMT's and SRNA's have been in-serviced on 6-5-15 thru 6-14-15 by the DON the Unit managers and shift supervisors regarding following each resident's care plan including turning and repositioning, toileting, assisting with meals, showers and baths, and promptly answering call lights.</p> <p><b>Systemic Changes</b> The facility has added a shower team to the additional current staffing on 6-8-15 consisting of 4 SRNA's to perform all showers as care planned for each resident. The SRNA's providing direct care to the resident's on the floor will no longer be responsible for giving showers which will allow them more time to answer call lights especially on the 3-11 shift.</p> <p>As of 6-8-15 shower sheets are being completed and turned into the DON to match the shower schedule to verify that all showers are being given as scheduled.</p> <p>Call light audits were initiated on 6-8-15 by the Administrator to be performed on each hall and on each shift including weekends Monday thru Sunday. The audits includes the room numbers, the time call lights go off and the time the call light is answered.</p> <p>The audits will be performed by the unit managers, 3-11 and the 11-7 shift supervisors Monday thru Friday and weekend supervisors on Saturday and</p>

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F 353	Continued From page 98  shift it sometimes took forty-five (45) minutes to an hour for staff to answer the call light if he/she needed to use the urinal or if he/she wanted the brief changed. Further interview revealed Resident #22 didn't like to be wet because it made him/her feel dirty when he/she was wet.  2. Record review revealed the facility admitted Resident #15 on 02/28/14, with diagnoses which included Dementia, Depression and Insomnia. Review of the Quarterly MDS Assessment dated 02/20/15, revealed the facility assessed Resident #15 to have a BIMS score of four (4) out of fifteen (15), indicating severe cognitive impairment. Review of the Certified Nursing Assistant (CNA) Care Plan Record for April 2015 revealed Resident #15 preferred showers, although there was no documented evidence of days or times. Continued review of the CNA Care Plan Record revealed Resident #15 preferred male staff's assistance for his/her showers.  Review of Resident #15's Shower Sheets for the months of January 2015 through April 2015, revealed between 03/12/15 and 04/22/15, a period of forty-one (41) days, there was no documented evidence Resident #15 either received or refused any showers. However, review of the resident's "Right to Refuse" Routine Care sheets, dated 01/21/15 and 02/18/15, revealed Resident #15 refused showers on those two (2) dates, as the showers were offered by a female CNA.  Interview with CNA #15 on 04/30/15, revealed he usually worked second shift, on Unit 1, and a lot of times only four (4) CNA's worked on the unit. CNA #15 stated there were quite a few times when there were only three (3) CNA's working on	F 353	Sunday. The call light audits will be reviewed daily Monday thru Friday by the Administrator for compliance. In addition to the call light audits, Social services and the Administrator are conducting room interviews weekly with 3 interviewable residents on each unit concerning call lights being answered timely or to enlist any resident care concerns.  <i>Monitoring</i> The facility implemented a shower team consisting of adding 4 SRNA's to the current staffing to complete all showers weekly. The back-up for the shower team consists of the staffing coordinator, medical records coordinator, Central supply coordinator who are certified SRNA's or a floor SRNA not scheduled for that day in case of a call in and/or vacation on the shower team. The staffing Coordinator, DON and the Administrator meets daily with the staffing schedules to go over staffing and to ensure call in's are covered to ensure adequate staffing is present to meet the needs of the resident's on all shifts Monday thru Sunday. The meeting to go over weekend staffing occurs on Fridays to ensure call in's are filled and that there is adequate staff scheduled for Saturday and Sunday. The facility will utilize agency, Administrative staff and enlist current staff to help cover call-in's when necessary to ensure adequate staffing to meet the care needs of the residents.	

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F 353	Continued From page 99 Unit 1 on second shift, and at times they didn't always have enough help to accommodate residents's care and requests. Per interview, sometimes Resident #15 would refuse showers, as he/she had done yesterday, 04/29/15. CNA#15 revealed however, Resident #15 would take showers. According to CNA#15, ideally sufficient staffing for the unit would be five (5) or six (6) CNA's for second shift. Further interview revealed when there wasn't sufficient staff, it was difficult to answer residents' call lights in a timely manner, although he and the other CNA's worked as hard as possible to do this, and did the best they could.  3. Record review revealed the facility admitted Unsamped Resident #A on 09/24/14, with diagnoses which included Intestinal Infections Due To Clostridium Difficile (C-diff), Sepsis and Urinary Tract Infection (UTI). Review of Unsamped Resident A's Quarterly MDS Assessment, dated 03/27/15, revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact.  Interview with Unsamped Resident #A on 05/02/15 at 8:15 AM, revealed he/she had to wait up to forty (40) minutes at least three (3) times recently on second and third shift for staff to respond to his/her call bell after an incontinent episode. Unsamped Resident #A stated it was important to be changed timely due to his/her history of UTIs. Per interview, it made him/her feel bad having to wait a long time for staff, as he/she didn't like lying in urine and feces. According to Unsamped Resident #A, staff didn't come into the resident's room and check on him/her at night, and when he/she awakened in	F 353	The Administrator reviews the actual staffing thru the payroll reports compared to the schedule every morning Monday thru Friday to ensure there was adequate staffing for the last 24 hours as a QA check. Call light audits were initiated on 6-8-15 by the Administrator to be performed on each hall and on each shift including weekends Monday thru Sunday. The audits includes the room numbers, the time call lights go off and the time the call light is answered. The audits will be performed by the unit managers, 3-11 and the 11-7 shift supervisors Monday thru Friday and weekend supervisors on Saturday and Sunday. The call light audits will be reviewed daily Monday thru Friday by the Administrator for compliance. In addition to the call light audits, Social services and the Administrator are conducting room interviews weekly with 3 interviewable residents on each unit concerning call lights being answered timely or to enlist any resident care concerns.  The results of the call light audits and resident scheduled shower compliance and staffing will be submitted to the monthly Quality Assurance and Safety committee meetings which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary by		

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F 353 Continued From page 100  
the morning, the water pitcher had not been filled. Further interview revealed the resident felt the facility needed more staff to help residents and for supervision, especially on the second and third shifts.

4. Record review revealed the facility admitted Unsampld Resident #B on 10/15/13, with diagnoses which included Hypertension, Hyperlipidemia, Alzheimer's Disease and Dementia. Review of the Quarterly MDS Assessment dated 02/27/15, revealed the facility assessed Unsampld Resident B to have a BIMS score of fourteen (14) out of fifteen (15), indicative of being cognitively intact.

Interview with Unsampld Resident #B on 05/04/15 at 11:30 AM, revealed the resident had waited as long as an hour or more for his/her call light to be answered. Per interview, not long ago on the second shift he/she rang the call light for assistance onto the bedside commode and was helped onto the bedside commode. Unsampld Resident B stated however, he/she sat on the commode for forty (40) minutes waiting for staff to come assist him/her after ringing the call light to alert staff to assist him/her off the bedside commode once he/she was done. Unsampld Resident #B further revealed, he/she had not had a bath in a week, as staff had said they did not have time to assist him/her with taking a bath.

5. Record review revealed the facility admitted Unsampld Resident #C on 11/12/10, with diagnoses which included Generalized Muscle Weakness, Anemia and Syncope and Collapse (Fainting). Review of Unsampld Resident #C's Quarterly MDS Assessment dated 02/13/15, revealed the facility assessed the resident to have

F 353 the Administrator and the DON for review and recommendations.

*Date of Correction:*  
6-26-15

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F 353	<p>Continued From page 101</p> <p>a BIMS score of fourteen (14) out of fifteen (15), indicating no cognitive impairment. Continued review of the MDS Assessment revealed the facility also assessed Unsampled Resident #C as requiring assist of one (1) with bathing.</p> <p>Interview with Unsampled Resident #C on 05/04/15 at 10:00 AM, revealed he/she was scheduled showers two (2) times weekly, and he/she sometimes had to wait for staff to be available to assist him/her. Unsampled Resident #C revealed showers were scheduled by shift, not by time, and he/she could not depend on getting a shower at any specific time.</p> <p>6. Record review revealed the facility admitted Unsampled Resident #D on 10/05/12, with diagnoses which included Anxiety State, Acute Pancreatitis and Difficulty Walking. Review of the Quarterly MDS Assessment dated 04/10/15, revealed the facility assessed the resident to have a BIMS score of nine (9) out of fifteen (15), indicating moderate cognitive impairment and to require assist of one (1) for bathing and ambulation.</p> <p>Interview with Unsampled Resident #D on 05/04/15 at 10:20 AM, revealed he/she was scheduled to get his/her showers on second shift; however, did not always get the showers on time. Per interview, the resident recently had a shower day, but staff did not approach him/her until 9:30 PM at night, when he/she was ready for bed. Unsampled Resident #D revealed he/she refused the shower at that time due to the late hour.</p> <p>Interview with CNA #10 on 04/30/15 at 10:50 AM, revealed when they were short-staffed on second shift, they were not able to meet all the residents'</p>	F 353	

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care needs. CNA #10 revealed showers and baths might not get done if they were short CNA's.

Interview with LPN #11 on 04/30/15 at 4:32 PM, revealed during the past two (2) months, staffing for the units had been down to four (4) CNA's on second shift. LPN #11 revealed this had an impact on resident care, causing longer waits for resident care to be done, and the CNA's not having time to do the residents' showers. LPN #11 revealed if they were short staffed, residents were often fed in their rooms instead of being taken to the dining room, and residents had to stay in bed longer in the morning before staff was available to help them get up.

Interview with CNA#12 on 05/01/15 at 11:44 AM, revealed they frequently worked short staffed on second shift. CNA #12 revealed when this was the case, they didn't have time to provide the residents' showers. She stated the CNA's answered call lights as quickly as they could. Per CNA #12, however, if they were passing trays, and there was only two (2) CNA's on the unit, it could routinely take ten (10) minutes or longer before they could respond.

Interview with CNA #11 on 05/01/15 at 2:21 PM, revealed she couldn't get her work done when there was only three (3) or four (4) CNA's on second shift. CNA #11 revealed there was no way they could give the residents' showers when they only had three (3) or four (4) CNA's working the unit. Per interview, there should be two (2) CNA's minimum on each hall or six (6) CNA's to a unit to ensure residents' care needs were met. CNA #11 revealed there had been gaps in the hydration documentation for each resident, which

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F 353	<p>Continued From page 103</p> <p>staff had been instructed to "fill in" despite not having the information, and she had refused to do this. Continued interview revealed she didn't take a lunch break when there was only three (3) CNA's on second shift, and although she had tried to explain her concerns to the Administrator, she was told he didn't want to hear them. CNA #11 stated residents had so many wounds and falls now due to not having enough staff. Per CNA #11, there was not enough CNA's to do the rounds, respond to call lights and turn and reposition residents. Further interview revealed when short staffed on second shift, call lights could ring for ten (10) minutes or longer, and nurses only responded to call lights "when state is here".</p> <p>Interview with CNA #16 on 05/02/15 at 8:14 AM, revealed when they were short staffed on second shift, they just got done what they could. CNA #16 revealed on 04/24/15, they had only had three (3) CNA's on second shift, not enough staff to provide the residents' showers which were not done. Per interview, although she didn't know how long it had taken to answer call lights, there had been residents tired of waiting or unable to wait any longer, getting up for toileting and experiencing falls as a result. CNA #16 revealed when short staffed they found themselves having to respond to residents alarms which were going off, to prevent the resident from having an accident. Further interview revealed the alarms might not have gone off if the units were adequately staffed and the CNA's had the time to respond more quickly to call lights.</p> <p>Interview, on 05/02/15 at 11:30 AM, with CNA #31 revealed he worked the evening shift and in the past six (6) months the staffing levels had really</p>	F 353	

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F 353 Continued From page 104  
decreased. He stated the CNA's could not provide the level of care to the residents which they needed because there was not enough staff on the evenings and weekends. Per interview, there was now usually four (4) to five (5) CNA's per unit where there used to be six (6) CNA's per unit consistently. CNA #31 revealed with so few CNA's on the units incontinence care and turning and repositioning which was to be done every two (2) hours, was only done twice a shift. He stated supper was over at 7:00 PM; however, it took until 9:30 PM to get the residents to bed which was too long for some residents to have to sit up after supper. Continued interview revealed when they worked short staffed oral care did not always get done before bedtime, ice water did not always get passed, and therapeutic snacks from the kitchen did not always get passed. Per CNA #31, this occurred almost every weekend. He revealed he had been told to use the mechanical lifts by himself if no one could assist him and to just close the door so no one would know; however, he had refused to do this. Further interview revealed the nurses did not help answer call bells and sometimes the call bells would ring over ten (10) minutes before someone could answer them. Further interview on weekends there was no supervisor or management in the facility to report concerns to.

Interview with CNA #26 on 05/02/15 at 11:32 AM, who worked on weekends revealed staffing was "terrible." CNA #26 revealed the last four (4) or five (5) weekends they had been short-staffed and when this occurred the residents' care suffered. Per interview, residents sometimes complained to her of not getting their showers during the week.

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F 353	<p>Continued From page 105</p> <p>Interview with CNA #17 on 05/03/15 at 11:50 AM, revealed on unit 2 they used to have five (5) or six (6) CNA's, which had now been cut down to four (4) CNA's, but they were still expected to do as much work with four (4) as they had used to do with five (5) or six (6) previously. CNA #17 revealed she didn't think they were answering residents' call lights fast enough, and when they were short staffed showers didn't get done. Further interview revealed when they were short staffed, they often had to leave one (1) resident care to go respond to the call light of another resident, leaving the first resident feeling neglected.</p> <p>Interview with LPN #4 on 05/04/15 at 3:15 PM, revealed staffing was "awful" on second shift. She revealed they usually had three (3) or four (4) CNA's, as there was a lot of call-ins. She revealed with only three (3) or four (4) CNA's they were not able to get the work done. Per interview, residents didn't get showers if there was only three (3) CNA's working, and the CNA's were also not able to do their rounds as per the protocol every two (2) hours. LPN #4 stated although the CNA's were to turn and reposition residents four (4) times during their shift, when there was only three (3) CNA's, they were only able to turn and repositions residents at the beginning of their shift, after dinner, and before they left work. Further interview revealed they had a lot of residents who required two (2) person assist, and due to the volume of work, a lot of CNA's didn't take their dinner break in order to provide more resident care.</p> <p>Interview with CNA#3/Quality Assurance (QA) Aide on 05/02/15 at 10:11 AM, revealed she did a lot of audits during first shift from 8:00 AM up until</p>	F 353	

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F 353 Continued From page 106

4:00 PM, during the week to ensure the CNA's were checking and changing and turning and repositioning residents, getting resident showers done, and responding to call lights. However, she reported she did not conduct audits on second or third shift. CNA #3/QA Aide revealed residents had reported call lights weren't being answered timely on other shifts, which she passed on to the Unit Managers and CNA's; however, did not report this information to the facility's QA Committee.

Interview with the QA Nurse on 05/04/15 at 10:50 AM, revealed there was no formal audit sheets to review on the evening shift or night shift related to call bell response times. Per interview, if these shifts were being audited for call bells she was not receiving the audits to analyze findings and take to the QA meetings. She stated the facility needed to be formally auditing all shifts for call bell concerns and response times.

Interview with the Unit 2 Manager on 05/04/15 at 3:31 PM, revealed on second shift they scheduled four (4) or five (5) CNA's for the unit, although there were a lot of call ins. The Unit 2 Manager revealed she had never known a unit to have less than three (3) CNA's on second shift, and when a unit was understaffed she did not believe the CNA's were able to get their work done. Further interview revealed although Unit 2 had a high acuity level, staffing was based on census and did not take into account the acuity of the resident population.

Interview with the Unit 1 Manager on 05/04/15 at 4:29 PM, revealed staffing was based on census, and there was typically three (3) nurses and four (4)CNA's on second shift. The Unit 1 Manager

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F 353: Continued From page 107

revealed when call ins occurred they tried to get coverage, but weren't always able to do so. Continued interview revealed the CNA's had complained to her about not being able to get their work done; however, had never specified what exactly they were not able to get done. Unit 1 Manager revealed the CNA's were not always turning in the resident shower sheets, especially when residents refused showers.

Review of the facility's Time and Attendance-Daily Report for 04/17/15, revealed three CNA's worked on Unit 1 and two (2) CNA's worked on Unit 2 on second shift. Continued review revealed on third shift, two CNA's were assigned to Unit 1 and two CNA's were assigned to Unit 2.

Review of the facility's Time and Attendance-Daily Report for 04/24/15, revealed two (2) CNA's worked on each unit during second shift. A third agency CNA reportedly had worked on at least one (1) of the units to supplement second shift staff; however, no documented evidence was provided to validate this.

Review of the facility's Time and Attendance-Daily Report for 04/25/15, revealed two (2) CNA's worked each unit on third shift.

Review of the facility's Time and Attendance-Daily Report for 04/26/15, revealed two (2) CNA's worked on each unit on the second shift. Again, no documented evidence of any agency staffing was provided to indicate a higher staffing level.

Interview with the Staffing Coordinator on 05/02/15 at 9:15 AM, revealed staffing was determined by census, and staff assignments was based on resident acuity. The Staffing

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F 353 Continued From page 108

Coordinator revealed the staffing for Unit 1 was for five (5) CNA's on second shift, and four (4) CNA's on Unit 2 on second shift. Per interview, second shift was hardest to staff, and once or twice a month despite efforts to fill the call-ins, second shift was short staffed. Further interview revealed she had not heard any complaints regarding resident care on second shift.

Interview with the Director of Nursing (DON) on 05/04/15 at 2:50 PM, revealed staffing was done according to census, not acuity. The DON revealed staffing on second shift was five (5) CNA's on each unit until 7:00 PM, at which time it went down to four (4) CNA's on each unit based on a resident census of one hundred and four (104). Per interview, four (4) CNA's were scheduled for Unit 1 on third shift, and three (3) CNA's were scheduled for Unit 2 on third shift. According to the DON, when there were call ins, which had occurred several times over the last two (2) months, the DON revealed they exhausted all efforts before they left a position unfilled. Continued interview revealed the DON's expectation was for residents to be turned and repositioned every two (2) hours, checked and changed every two (2) hours, and call lights should be answered promptly. The DON revealed although there had been some resident grievances related to call bells, there had been no grievances regarding lack of resident care. Further interview reveled if call bells were not answered timely, it could contribute to resident wounds or falls.

Interview with the Administrator on 05/04/15 at 4:40 PM, revealed his expectation was for resident care to be provided in an acceptable manner. He stated he expected call bells to be

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F 353 Continued From page 109  
answered expeditiously. Per interview, he had a staffing grid he used which took in to account both acuity and census in deciding the number of staff needed in the facility. Continued interview revealed there should be at least six (6) nurses and ten (10) CNA's in the facility on second shift until after dinner, at which time two (2) CNA's could leave early. The Administrator stated on third shift there should be four (4) nurses and seven (7) CNA's in the facility and the same numbers were expected on the weekends for second and third shifts. According to the Administrator, when the model (staffing grid) was used related to the correct number of staff, he felt the work got done. However, he revealed when there were call ins, they might not meet their minimum staffing requirements. He stated it was his preference for the call ins to be filled with their own staff; however they did use agency staff sometimes. Further interview revealed if staff did not give at least a two (2) hour notice before their shift started for the call in, they were unable to get agency staff to cover. The Administrator revealed when there was a call in, either he, the DON or the Staffing Coordinator would attempt to get coverage. Further interview revealed he reviewed the staffing from the previous day on a daily basis to find out how many staff were actually working. Per the Administrator, there were some outliers when circumstances came up which could not be controlled, and he had not calculated how often this occurred. The Administrator revealed the facility had open positions currently.

F 353

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  
SS=D

F 411 F 411 D

The facility must assist residents in obtaining

*Residents Affected*  
Resident #5 was seen by the attending physician for an oral exam on 5-26-

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PRINTED: 05/29/20  
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F 411 Continued From page 110  
routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents were provided the opportunity to receive routine dental services for two (2) of twenty-two (22) sampled residents (Resident #5 and Resident #7).

The findings include:

Review of the facility's "Dental Policy", revised April 2014, revealed oral health services were available to meet residents' needs in accordance with the resident's assessment and plan of care.

Interview with the Social Services Director (SSD) on 05/04/15 at 10:50 AM, revealed the facility's current process for dental services was to offer the services on admission and if the resident and/or his/her Power of Attorney (POA) requested dental services the dental provider was notified.

1. Review of Resident #5's medical record

15 and has been referred to the dentist which is scheduled for 6-23-15.

Resident #7 was seen by the attending physician for an oral exam on 5-26-15 and has been referred to the dentist which is scheduled for 6-23-15.

**Identification of Other Residents**  
All residents in the facility has a potential to be affected. The social services director has verified that the residents who have consented for dental services has been seen by a dentist in 2014. No other residents were identified as having a missed dentist visit in 2014.

**Systemic Changes**  
The social services has created an audit sheet consisting of the resident's name, date of admission, consent for dental services, date of dental service received. This audit is updated with each new admission. A dentist list will be made out by social services for the dentist prior to the dental visit and the residents who received a visit will be charted on the audit list to ensure that each resident who consented for the service were seen.  
If any resident was missed by the dentist, the social worker will notify the dentist for a revisit to occur to see any resident missed.  
On admission and readmission a consent form for dental services are obtained by the social services director and placed on the schedule

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F 411 Continued From page 111

revealed the facility re-admitted the resident on 06/03/14, with diagnoses which included Peripheral Vascular Disease, Renal Failure and Dementia. Review of the Minimum Data Set (MDS) Assessment dated 04/10/15, revealed the facility assessed Resident #5 as having a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15), indicating severe cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #5 as not having any dental or oral health concerns. Continued review of Resident #5's medical record revealed a consent for dental services had been signed by the resident's Power of Attorney (POA) on 03/11/13.

Review of the Dental Provider "Patient Progress Note" dated 04/30/13, revealed Resident #5 was examined by a dental provider on that date. Continued review of the Note revealed the dental provider noted Resident #5 was edentulous and had dentures.

Continued review of Resident #5's medical record revealed no documented evidence of further routine dental examinations after 04/30/13.

Review of a list of residents who "were scheduled for an annual dental visit on 12/09/14", revealed three (3) residents names, one (1) of which was Resident #5.

Interview with the SSD on 04/30/15 at 2:30 PM, revealed Resident #5 did not get seen on 12/19/14, for the annual dental examination because of the dental provider's time constraints. Per interview, the dental provider had scheduled sixteen (16) established residents and (2) new residents for that date, but had been unable to

F 411 along with the current residents who have consented for dental services. The next annual dentist visit is scheduled for December, however extra visits can be scheduled if needed. If the need arises for a dental visit before the annual scheduled visits, the dentist will be notified by the social services director.

**Monitoring**  
The social services has created an audit sheet consisting of the resident's name, date of admission, consent for dental services, date of dental service received. This audit is updated with each new admission. A dentist list will be made out by social services for the dentist prior to the dental visit and the residents who received a visit will be charted on the audit list to ensure that each resident who consented for the service were seen. If any resident was missed by the dentist, the social worker will notify the dentist for a revisit to occur to see any resident missed. The social services director will submit the resident dental visit compliance to the monthly Quality Assurance and Safety Committee meetings which consists of the Medical Director, DON, Administrator, Consultant, pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review and recommendations.  
**Date of Correction:**

6-26-15

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F 411 Continued From page 112  
see Resident #5 and two (2) other residents. The SSD stated Resident #5 had been rescheduled to be seen on 06/23/15.

2. Review of Resident #7's medical record revealed the facility re-admitted the resident on 02/19/15, with diagnoses which included Diabetes, Anxiety, Depression and Schizophrenia. Review of the Quarterly MDS Assessment dated 03/13/15, revealed the facility assessed Resident #7 as having a BIMS score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact. Continued review of the MDS revealed the facility had assessed Resident #7 as not having any dental or oral health concerns. Continued review of the medical record revealed a consent for dental services had been signed by his/her POA on 07/31/12.

Review of the dental provider's "Patient Progress Note" dated 11/20/12, revealed Resident #7 was examined on that date and the dental provider noted the resident had not been wearing his/her dentures. Review of the dental provider's "Patient Progress Note", dated 11/26/13, revealed Resident #7 was seen by the dental provider on that date.

Continued review of Resident #7's medical record revealed no documented evidence of further routine dental examinations after 04/30/13.

Review of a list of residents who "were scheduled for an annual dental visit on 12/09/14", revealed three (3) residents names, one (1) of which was Resident #7.

Continued interview with the SSD on 04/30/15 at

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F 411 Continued From page 113  
2:30 PM, revealed Resident #7 was also not seen by the dental provider on 12/19/14, due to the dental provider's time constraints. The SSD stated Resident #7 had been rescheduled to be seen on 06/23/15. However, further interview with the SSD on 05/04/15 at 10:50 AM, revealed at the current time the facility did not have a process in place to ensure all residents were offered routine dentist services on an annual basis.

F 411

Interview with the Director of Nursing (DON) on 05/04/15 at 2:05 PM, revealed the facility's process was for dental services to be offered upon admission and if the new resident elected to receive dental services the dental provider was notified. She further stated it was the SSD's responsibility to ensure all State and Federal regulations were met regarding resident's annual routine dental examinations.

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

F 441 F 441 E

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.

*Residents Affected*  
The RN staff educator and the Infection control nurse has performed Glucometer Disinfection Competencies on the licensed staff including the RN's, LPN's, and CMT's on 5-28-15 thru 6-14-15.

- (a) Infection Control Program  
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
  - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
  - (3) Maintains a record of incidents and corrective actions related to infections.

The RN staff educator, QA nurse and the Infection control nurse has performed Hand washing competencies on the licensed staff including the RN's, LPN's, CMT's and SRNA's on 5-28-15 thru 6-14-15. The infection control nurse audited each resident in isolation on 6-8-15 for having the appropriate isolation

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F 441 Continued From page 114

(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, Centers for Disease Control (CDC) and Prevention Guidelines and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of twenty-two (22) sampled residents (Resident #2) and two (2) of ?? unsampled residents (Unsampled Residents C and F).

F 441 signage on the door for staff and visitors.

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday, and the weekend supervisors on Saturday and Sunday are performing daily observations of at least one licensed and one unlicensed staff member entering and exiting isolation rooms for hand washing adherence.

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday and the weekend supervisors on Saturday and Sunday are performing daily observations of at least one licensed staff member performing glucometer blood sugar checks for adherence of cleansing machine between resident uses.

Resident #2 is still in isolation and staff is adhering to proper hand washing when entering the room and before exiting the room when care is being provided including wound care treatments.

All residents who are in isolation has the appropriate isolation signage on the doors.

Resident #F is receiving blood sugar accuchecks as ordered only after the glucometer has been cleansed properly between patient uses. The resident's graduate cylinders, urinals, bedpans and toothbrushes are labeled, bagged and stored properly.

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F 441 Continued From page 115

Observation of Resident #2's a dressing change, who was in contact isolation for Methicillin Resistant Staphylococcus Aureus (MRSA) and Carbapenem Resistant Enterobacteriaceae (CRE), revealed the nurse placed a barrier under the resident's left leg, then proceeded to remove her gloves and gown, and without washing or sanitizing her hands, exited the room to obtain a bandage from the treatment cart. Further observation revealed the nurse returned, cleansed and measured the wound on Resident #2's left leg, then removed her gloves and gown and exited the room again without washing or sanitizing her hands. The nurse sanitized her hands in the hallway after exiting the room.

Additionally, observation revealed there was no isolation signs on the doors to rooms 606 and 610 identifying the type of precautions to be used and educating visitors to see nurse before entering the room. However, staff interviews revealed the residents residing in those rooms were in isolation related to having Clostridium difficile infections (a highly contagious bacterial infection).

Observation of a finger stick blood sugar (FSBS) performed for Unsampled Resident C by the nurse revealed the nurse performed the FSBS, washed her hands and exited the resident's room. The nurse then observed, without disinfecting the glucometer, to enter Unsampled Resident F's room and perform a FSBS for Resident F.

Also, observation on initial tour revealed graduate cylinders and bed pans unlabeled and unbagged in residents' shared bathrooms. In addition, toothbrushes in residents' shared rooms located

*Identification of Other Residents*

F 441 All the residents in the facility has a potential to be affected. The RN staff educator and the Infection control nurse has performed Glucometer Disinfection Competencies on the licensed staff including the RN's, LPN's, and CMT's on 5-28-15 thru 6-14-15.

The RN staff educator, QA nurse and the Infection control nurse has performed Hand washing competencies on the licensed staff including the RN's, LPN's, CMT's and SRNA's on 5-28-15 thru 6-14-15. The infection control nurse audited each resident in isolation on 6-8-15 for having the appropriate isolation signage on the door for staff and visitors.

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday, and the weekend supervisors on Saturday and Sunday are performing daily observations of at least one licensed and one unlicensed staff member entering and exiting isolation rooms for hand washing adherence.

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday and the weekend supervisors on Saturday and Sunday are performing daily observations of at least one licensed staff member performing glucometer blood sugar checks for adherence of cleansing machine between resident uses.

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F 441 Continued From page 116  
at the sink were not labeled with the residents' names.

The findings include:

1. Review of the facility's policy titled, "Handwashing/Hand Hygiene", revised August 2014, revealed hand hygiene was the primary means to prevent the spread of infections. The Policy stated staff should wash their hands with soap and water when their hands were visibly soiled and after contact with residents with infectious diarrhea. Continued review revealed staff could use an alcohol based hand rub containing at least 62% alcohol or soap and water for the following situations: before and after direct contact with residents; and before and after entering residents' isolation rooms. Per the Policy, hand hygiene was the final step after removing and disposing of personal protective equipment (PPE), and the use of gloves did not replace hand washing or hand hygiene.

Review of the facility's, "Procedure for Isolation: Initiation of Isolation Precautions Reference 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings", June 2007, revealed staff should wear clean gloves when entering the room of a resident in isolation. Continued review revealed staff should wear a gown when entering a resident isolation area if substantial contact with the resident, his/her items, or environmental surfaces was anticipated. Further review revealed the gown should be removed before staff left the resident's room and hands should be washed prior to leaving the room.

Record review revealed the facility admitted

F 441 The Infection Control nurse has audited each resident's room for proper labeling, bagging and storage of graduate cylinders, bedpans, urinals and toothbrushes on 6-14-15.

**Systemic Changes**  
The Infection control nurse in-serviced the nursing department including the SRNA's and licensed staff on 5-28-15 thru 6-14-15 on isolation precautions and the procedures to follow when a resident is placed in isolation including signage.  
The infection control nurse will audit each resident in isolation and the residents who are placed in isolation for appropriate set-up including isolation signage daily Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. These audits will be turned into the DON for review and compliance.

The Infection control nurse in-serviced the nursing department including the SRNA's and licensed staff including RN's, LPN's and CMT's on 5-28-14 thru 6-14-15 on hand washing and performed a hand washing competency. This hand washing competency has been added to the new hire and agency orientation.

The Infection control nurse in-serviced the nursing department including the SRNA's and licensed

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F 441 Continued From page 117  
Resident #2 on 09/30/14, with diagnoses including Chronic Obstructive Pulmonary Disease, Cerebral Vascular Accident and Diabetes Mellitus. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 01/27/15, revealed the facility assessed the resident as cognitively intact and to have one (1) Stage III Pressure Ulcer (PU).

Review of the 04/23/15 Hospital Discharge Summary revealed Resident #2 was hospitalized from 04/03/15 until 04/23/15, and treated with intravenous (IV) antibiotics for lower extremity Cellulitis. Further review revealed Resident #2 was discharged from the hospital with diagnoses which included Venous Stasis, Bilateral Heel Ulcers, Status Post Debridement and Xenograft Application (surgical tissue graft), and a heel infection positive for CRE (a bacteria resistant to most available antibiotics), Pseudomonas (a bacteria which could lead to severe illness or death of people with weakened immune systems) and MRSA (an antibiotic resistant bacteria).

Review of the Re-admission Physician's Orders dated 04/23/15, revealed orders for Resident #2 to be placed in Contact Precautions and for Zosyn (an antibiotic medication) 3.375 milligrams (mgs) IV via a PICC (peripherally inserted central catheter for intravenous access) line every six (6) hours for seven (7) more days.

Observation of a skin assessment and dressing change on 04/29/15 from 2:25 PM until 4:00 PM, revealed Licensed Practical Nurse (LPN) #6 placed a barrier under Resident #2's left leg, then removed her gloves and gown, and exited the room without washing or sanitizing her hands. Continued observation revealed LPN #6 reached

F 441 staff including RN's, LPN's and CMT's on 5-28-14 thru 6-14-15 on proper bagging, labeling and storage of personal items. This has been added to the new hire and agency orientation.

The infection control nurse will perform weekly room audits to validate that personal items are being bagged, labeled and stored properly. This audit will be turned into the DON for review and compliance.

The Infection control nurse in-serviced the licensed staff including RN's, LPN's and CMT's on 5-28-15 thru 6-14-15 on Glucometer Disinfection and has performed Glucometer Disinfection Competencies on the licensed staff including the RN's, LPN's, and CMT's on 5-28-15 thru 6-14-15. This has been added to the new hire and agency orientation.

**Monitoring**

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday, and the weekend supervisors on Saturday and Sunday are performing daily observations of at least one licensed and one unlicensed staff member entering and exiting isolation rooms for hand washing adherence.

The infection control nurse, 3-11 and 11-7 shift supervisors Monday thru Friday and the weekend supervisors on Saturday and Sunday are performing daily observations of at

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F 441 Continued From page 118

in her pocket and obtained keys, then opened the treatment cart drawer and removed a bandage. The nurse was observed to then don a new gown, and re-enter Resident #2's room and wash her hands. Observation revealed LPN #6 removed the soiled dressing from Resident #2's left lateral leg wound, cleansed the wound with Normal Saline (N/S), washed her hands, donned new gloves and measured the wound. Further observation revealed the nurse removed her gloves and gown, and again exited the room without washing her hands and sanitized her hands in the hallway.

Interview with LPN #6 on 04/29/15 at 4:00 PM, revealed she had been observed by the facility's administrative staff performing wound care in the past with no problems identified. She stated however, she should always wash her hands before exiting a resident room after providing care for infection control purposes.

Interview with the Director of Nursing (DON) on 05/02/15 at 8:00 AM, revealed it was her expectation staff wash their hands prior to exiting a resident's room. The DON revealed it would be especially important for staff to wash their hands after providing care for a resident in isolation to prevent the spread of infections.

2. Continued review of the facility's, "Procedure for Isolation: Initiation of Isolation Precautions", revealed contact precautions were used in addition to standard precautions for residents known to be infected with microorganisms which were transmitted easily by direct or indirect contact with environmental surfaces or resident care items. Further review of the Guideline revealed the resident, family and staff were

F 441 least one licensed staff member performing glucometer blood sugar checks for adherence of cleansing machine between resident uses.

The audits turned into the DON regarding the compliance with isolation set-up and signage, and the audits for properly bagged, labeled and storage of personal items, the audits of staff compliance with hand washing adherence and glucometer cleansing between resident uses, will be submitted to the monthly Quality Assurance and Safety committee meeting which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary by the DON for review and recommendations.

*Date of Correction:*  
6-26-15

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F 441	Continued From page 119 informed of the need for Isolation Precautions and the appropriate signage was to be posted outside the resident's door frame.	F 441		
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Observation during initial tour of the facility on the 600 hall, on 04/28/15 at 11:50 AM, revealed residents' rooms 606 and 608 had supplies of PPE on the outside of the room doors; however, there was no evidence of signage posted related to the type of isolation precautions the residents were in, and/or to see the nurse prior to entering the resident's room. Interview, on 04/28/15 at the time of observation, with the Assistant Director of Nursing (ADON), revealed the rooms had residents who had Clostridium difficile (C-diff) infections. Per the ADON, the rooms were supposed to have signage on the door to let staff know to use contact precautions when caring for the residents and to alert visitors to stop at the nurse's station. The ADON revealed not having signs posted was an infection control concern as visitors would not know to talk to a nurse prior to entering the residents' rooms and therefore, would not be educated about the necessary infection control measures prior to entering the room.

Interview, on 04/30/15 at 2:41 PM, with Certified Nursing Assistant (CNA) #25 revealed he worked on the 600 hall, and the contact precaution door signs were very important so staff knew what PPE items to use prior to entering the rooms. Per interview, the signs were also important for visitors as they alerted visitors not to just walk in the room and to see the nurse before entering contact isolation residents' rooms. CNA #25 stated visitors needed to be educated to take precautions before entering the residents' rooms.

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F 441 Continued From page 120  
Interview, on 04/28/15 at 2:23 PM, with Registered Nurse (RN) #2/UC revealed residents who were on contact precautions were supposed to have signs posted on the door so staff were aware of the type of PPE to don prior to entering residents' rooms to provide care. Per interview, it was important for staff to know the type of precautions and PPE in order to prevent the spread of the organisms. RN #2/UC revealed having the signs in place was also important to alert visitors to see the nurse prior to entering the residents' room. She stated the visitors needed to be educated by the nurse on the proper hand washing and PPE to use when visiting residents on contact precautions.

F 441

Interview, on 04/30/15 at 5:25 PM, with LPN #5, the facility's Infection Control Nurse (ICN) revealed if a resident had a multi-drug resistant organism (MDRO), such as C-diff, a supply of PPE was placed on the door and signage was posted on the door to indicate the type of precautions, used so staff were aware. Per LPN #5/ICN, the purpose of the "See The Nurse" sign was to ensure staff and visitors were educated on the proper infection control precautions to use when entering the residents' rooms. Per interview, the facility's current system used for residents in precautions was for housekeeping staff to put the PPE on the resident's door, and for nursing to put the signage on the door. Continued interview revealed she felt like there was a breakdown in the system however, as the signage had not been posted. She revealed the facility was going to look at having one (1) department responsible for placing the PPE and the signage. LPN #5/ICN further revealed the consequences of not having the signs on the residents' doors was the potential of cross

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F 441 Continued From page 121  
contamination and infection of staff and other residents. In addition, LPN #5/ICN revealed there was the potential of contamination of other areas if visitors were not aware to see the nurse and be educated on the precautions necessary prior to entering rooms of residents with precautionary measures in place.

3. Review of the CDC and Prevention Guidelines titled, "Infection Prevention during Blood Glucose Monitoring and Insulin Administration", updated 05/02/12, revealed if blood glucose meters were shared the device should be cleaned and disinfected after every use per the manufacturer's instructions.

Review of the facility's policy titled, "Obtaining a Fingerstick Glucose Level", revised December 2011, revealed when performing the fingerstick glucose procedure staff should use a disinfected blood glucose meter (glucometer) with a sterile lancet or a single resident use spring loaded device. Per the Policy, staff should always ensure the blood glucose meters intended for use were cleaned and disinfected between resident uses. Further review of the Policy revealed staff were to clean and disinfect reusable fingerstick glucose equipment between uses according to the manufacturer's instructions and current infection control standards of practice.

Review of the manufacturer's instructions titled, "EvenCareG2 Caring for the Meter", undated, revealed the following products were "validated" for disinfecting the EvenCareG2 fingerstick blood glucose meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach; Medline Micro Kill + Disinfecting, Deodorizing, Cleaning Wipes with Alcohol; Clorox Healthcare Bleach

F 441

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F 441	<p>Continued From page 122</p> <p>Germicidal and Disinfectant wipes; and Medline Micro Kill Bleach Germicidal Bleach Wipes. Per the manufacturer's instructions all external areas of the meter and/or lancing device should be wiped including both front and back surfaces with soap and water until visibly cleaned. To disinfect the meter, the meter surface should be cleaned with one (1) of the disinfecting wipes listed above. Further review revealed the surface of the meter or lancing device should be allowed to remain wet at room temperature at least thirty (30) seconds for the Medline Micro Kill Bleach Germicidal Bleach Wipes; at least one (1) minute for the Dispatch Hospital Cleaner Disinfectant Towels with Bleach and Clorox Healthcare Bleach Germicidal and Disinfectant wipes; and at least two (2) minutes for Medline Micro Kill + Disinfecting, Deodorizing, Cleaning Wipes with Alcohol.</p> <p>Observation, on 04/29/15 at 7:35 AM, revealed LPN #14 obtained a FSBS on Unsampled Resident C, washed her hands and exited the room with the glucometer. LPN #14 was observed to place the glucometer on the medication cart and gather supplies including lancets, test strips and alcohol pads. The nurse was then observed to go to Unsampled F's room with the same glucometer, which had not been disinfected after use on Unsampled Resident C, and place the glucometer on Unsampled Resident F's bedside table. The Surveyor asked to speak with LPN #14 out in the hallway prior to the nurse obtaining Unsampled Resident F's FSBS. The surveyor interviewed LPN #14 about the facility's protocol related to cleaning and disinfecting the glucometer after each use. LPN #14 revealed where she worked previously the glucometers had been cleaned by staff</p>	F 441		
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F 441 Continued From page 123

performing the FSBS after each use. LPN #14 stated however, she had been currently employed at the facility for a year, and the facility did not clean glucometers after each use. Although the Surveyor discussed with LPN #14 the possibility of cross contamination if the glucometer was not cleaned and disinfected after each use, the LPN proceeded to re-enter Unsampld Resident F's room and obtain the FSBS using the glucometer which had not been cleaned and disinfected after use on Unsampld Resident C.

Interview, on 04/29/15 at 8:00 AM, with the Unit Coordinator (UC), on the 100 Unit where LPN #14 was working, revealed staff had been trained on cleaning and disinfecting glucometers after each use. Per the UC, staff were to use bleach wipes on all surfaces of the glucometer and let it air dry for one (1) minute. She stated she did not observe "accuchecks" (FSBS) on her unit; however, stated the nurse should have come to her if she had a question about cleaning the glucometers.

Interview, on 04/30/15 at 6:00 PM, with Staff Development Nurse (SDN) #1, revealed she taught newly hired nursing staff how to clean the facility's glucometers and refreshed the nurses on the procedure when needed. She stated LPN#14 was in the class which she taught on 02/18/15; however, did not sign that she attended according to SDN #1's Record of Inservice Training. Further interview revealed staff were to use Micro Kill Bleach Germicidal Bleach Wipes for cleaning and disinfecting the glucometers, and were to ensure the surfaces remained wet as per the instructions for the five (5) minute contact time to kill the organisms listed on the label.

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F 441 Continued From page 124 F 441

Interview with the DON on 04/29/15 at 9:00 AM, revealed nurses were trained on hire related to cleaning and disinfecting the facility's glucometers. Per the DON, staff were to use the Micro Kill Bleach Germicidal Bleach Wipes, and not the Clorox Healthcare Bleach Germicidal and Disinfectant Wipes. She stated the surface of the glucometer needed to be wiped down and a waterproof barrier, not a paper towel, was to be placed under the glucometer after it was cleaned until the meter was dry.

4. Review of the facility's, "General Infection Prevention and Control Nursing Policies", undated, revealed all personal items would be appropriately labeled with the resident's name and stored in the bedside stands or other appropriate storage areas. Per the Policies, all items used for resident care would be cleaned and disinfected and would be designated for that resident's use only.

Observation on initial tour on 04/28/15 at 11:45 PM, revealed a graduate cylinder on the back of the toilet of a shared bathroom between resident Rooms 410 and 412 which was unlabeled and uncovered/unbagged, and a graduate cylinder on the back of a toilet of a shared bathroom between resident Rooms 411 and 409 which was unlabeled and uncovered/unbagged. Continued observation revealed a graduate on the back of the toilet of the shared bathroom for resident Room 407 which was unlabeled and uncovered/unbagged, a urine collection hat unlabeled and uncovered/unbagged, and a bed pan stored unlabeled and uncovered/unbagged on the side rail in the bathroom.

Interview, on 04/28/15 at 12:40 PM, with LPN #12

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F 441 Continued From page 125

who was assigned to the hall, revealed the graduate cylinders, bed pans and urine collection hats were to be labeled with the resident's name and bagged when stored. She stated she made rounds in the rooms with the unlabeled and unbagged items; however, had not noticed the items.

Observation during initial tour of the facility on 04/28/15, on the 600 hall, with the ADON, at 11:25 AM, revealed on a sink counter in a room shared by two (2) residents, Room 610, there were two (2) toothbrushes lying in an emesis basin which were unlabeled. In addition, in the shared bathroom connected to Room 610, there were two (2) unlabeled and uncovered/unbagged urinals observed on a bathroom hand rail. Interview with the ADON, at the time of observation, revealed all the items should have been labeled and covered as that was an infection control concern.

Observation at 12:05 PM, revealed in the shared bathroom between resident Rooms 601 and 603, there were two (2) bed pans stored on the bathroom hand rail which were not labeled and one (1) of the bed pans was not covered in a plastic bag. Interview with the ADON, at the time of observation revealed items stored unlabeled and uncovered in shared resident areas was an infection control concern related to possible cross contamination between residents.

Continued interview, on 04/30/15 at 2:41 PM, with CNA #25 revealed resident items, such as, toothbrushes and bed pans were supposed to be bagged and labeled with the resident's name. Per CNA #25, the resident urinals were also supposed to be labeled with their names. Further

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F 441 : Continued From page 126  
interview revealed staff wouldn't want the items "getting mixed up" between residents because of the possible spread of germs between residents.

Continued interview, on 04/28/15 at 2:23 PM with the RN #2/Unit Coordinator revealed residents' personal care items, such as, toothbrushes, bed pans and urinals were supposed to be labeled and the bed pans were supposed to be bagged to prevent cross contamination between residents.

Continued interview, on 04/30/15 at 5:25 PM, with LPN #5/ICN revealed residents' personal care items, such as, toothbrushes, bed pans and urinals were supposed to be labeled and separated from other resident items if stored in a common (shared)bathroom. LPN #5/ICN revealed labeling items prevented the potential of the item being used for another resident and to prevent cross contamination. Per interview, the bed pans should have been bagged due to the risk of contamination with organisms in the environment. LPN#5/ICN further revealed the CNA's were trained by the facility to label all resident personal items and store the items properly.

Interview, on 05/01/15 at 4:05 PM and on 05/02/15 at 8:00 AM, with the DON revealed residents' bed pans were supposed to be labeled with the resident's name, bed and room number, placed in a plastic bag and stored in the bathroom. The DON revealed the urine collection hats and graduate cylinders were to be labeled with the resident's name and stored in a plastic bag for residents who shared bathrooms. Further interview revealed by being unlabeled or not stored properly there was a risk of cross contamination and potential for infection for the

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F 441 Continued From page 127 residents.

F 514 483.75(I)(1) RES  
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure clinical records were accurate and complete for one (1) of twenty-two (22) sampled residents (Resident #22).

On 02/26/15, Resident #22 displayed behavior symptoms of yelling, cursing and throwing items at Certified Nursing Assistant (CNA) #7. Resident #22 also reported an allegation of employee CNA #7 calling him/her a "nigger" to staff on 02/26/15 and 03/12/15. However, other than the facility's Behavior Monitor Record document for Resident #22 dated 02/26/15, there was no documented

F 441

F 514 **F 514 D**  
**Residents Affected**  
On 5-6-15 Resident #22 medical record was reviewed by the social services director and the MDS coordinator for any behaviors not addressed in the comprehensive care plan and social services progress notes.

**Identification of Other Residents**  
All residents has the potential to be affected. Interviews were conducted with 52 residents assessed as having a BIMS score of 8 and above for any allegations of abuse or breach of dignity or unresolved grievances starting 5-7-15 thru 5-13-15 which were conducted by the Administrator, Social Services Director and Human Resources Director.  
In addition, the social services directors performed a psychosocial well-being check on 48 the residents with a BIMS score below 8 to identify any signs and symptoms of distress. No concerns were identified. This was completed on 5-13-15.  
Review each resident's care plan including Resident #22 for behaviors and appropriate interventions by the social services director and the MDS coordinators from 5-7-15 thru 5-13-15.

**Systemic Changes**  
The MDS coordinators along with the care planning team were re-inserviced on 6-10-15 and by the RN Regional Clinical Director on the MDS process and documentation of the resident care plan meetings including behaviors, concerns, complaints, grievances and resolutions. Any concerns, complaints, grievances obtained during the resident's

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F 514 : Continued From page 128  
evidence facility nursing or Social Services staff documented the the incident on 02/26/15 to include Resident #22's allegation of the CNA calling him/her a derogatory name and any related actions taken. In addition, even though Resident #22 informed the staff present in his/her Interdisciplinary Care Plan Conference meeting, on 03/12/15, of the incident on 02/26/15, there was no documented evidence of this in the resident's medical record to include the Conference Care Plan Record Summary.

The findings include:

Review of the facility's policy titled, "Charting and Documentation", revised April 2008, revealed all services provided for a resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record. Further review revealed the information to be documented included all observations, services performed, all incidents, and/or changes in the resident's condition.

Review of Resident #22's medical record revealed the facility admitted him/her on ???, with diagnoses which included ???. Review of the 03/27/15 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #22 as cognitively intact.

Review of the facility's Behavior Monitor Record form, dated 02/26/15 at 9:30 PM, revealed Resident #22 had behavioral symptoms of physical and verbal behaviors directed towards others. Review of the written statement, on the back of the Form, signed by CNA's #7, #13, and #25, revealed during a fire drill that day, Resident #22 displayed behaviors which included yelling,

F 514: scheduled care plan meeting per the RAI process will be reported to the administrator and the DON and documented in the medical record. A copy of each resident care plan summary will be submitted to the DON for review and follow-up of any concerns or grievances voiced by the resident which will include review of the medical record for proper documentation and follow-up.

A new Interdisciplinary Plan of Care (IPOC) program was implemented on 5-7-15 by the DON. The IPOC team members includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the Administrator and meets Monday thru Friday. If an admission or readmission occurs on the weekends, the house supervisor will audit the medical record utilizing the QA nurse's new admission/readmission audit form and turn the audit into the DON on Monday. The IPOC program was implemented to review of new admission residents, resident's readmissions, 24-hour reports, incident reports, all physician orders obtained in the last 24 hours, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident and to review the documentation in the medical record.

In-servicing for all staff began on 5-7-15 through 5-13-15 on reporting, investigating and documenting behaviors and/or allegations of verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect. The in-servicing will be conducted by the RN nurse educator after receiving education from the Regional Director of Clinical Services. Post-tests was conducted after the in-servicing.

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F 514 Continued From page 129  
throwing items and calling CNA #7 a "bitch". Continued review of the written statement revealed Resident 22 reported to CNA#25, during the incident, CNA #7 had called him/her a "nigger". Further review of the Behavior Monitor Record form revealed the report was signed by a Licensed Practical Nurse (LPN) as the supervisor.

However, continued record review revealed no documented evidence nurses or Social Services staff had addressed the incident of Resident #22's verbal and physical behaviors reported by the CNA's on 02/26/15. Additionally, there was no documented evidence of any follow-up assessments with Resident #22 related to his/her behaviors.

Review of Resident #22's Interdisciplinary Team Care Conference Record, dated 03/12/15, revealed the conference summary noted the Quarterly Assessment was completed and no significant change was noted. Continued record review revealed no documented evidence of any associated Social Services Progress Notes related to the information discussed in the care plan meeting.

Interview, on 05/02/15 at 8:25 AM and 11:41 AM, with Resident #22 revealed about two (2) months ago an "aide" had called him the "N" word which he/she had informed staff of at the time of the incident. Per interview, also during his/her care conference about two (2) months ago, Resident #22's family member brought up the incident of the "aide" calling the resident the "N" word and this was discussed during the care conference.

Interviews, on 05/04/15 with CNA #25 at 10:38

F 514 The Social Services will start receiving a copy of all physicians' orders each morning to review for any deletion, addition or changes in psychoactive medications and the 24 hour reports each morning for any new and or escalating behaviors and/or resident psychosocial issues that may need to be documented, reported or investigated.

**Monitoring**  
The MDS coordinators will submit a copy of each resident care plan meeting summary to the DON for review and follow-up of any concerns or grievances voiced by the resident which will include review of the medical record for proper documentation and follow-up. The DON will report findings to the monthly Quality Assessment and Safety Committee meetings for review of compliance and recommendations.

The IPOC team members which includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the Administrator and meets Monday thru Friday. If an admission or readmission occurs on the weekends, the house supervisor will audit the medical record utilizing the QA nurse's new admission/readmission audit form and turn the audit into the DON on Monday. The IPOC program was implemented to review new admission residents, resident's readmissions, 24-hour reports, and incident reports; all physician orders obtained in the last 24 hours, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident and to review the documentation in the medical record.

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F 514. Continued From page 130  
AM, CNA #7 at 12:29 PM, and CNA #13 at 1:15 PM, revealed during a fire drill, on 02/26/15. Resident 22 got upset and displayed verbal and physical behaviors of yelling, cursing and throwing items. CNA #25 revealed Resident #22 reported to him CNA #7 had called him the "N" word, and the resident had called CNA #7 the "B" word. Per CNA #25, Resident #22 stated if CNA #7 reported what the resident had said, then he/she was going to report CNA #7 for calling him/her the "N" word. They all revealed reporting the incident to a nurse, who was no longer employed by the facility, and she had them initiate the Behavior Monitor form. CNA#7 revealed the next day, 02/27/15, she also informed the Social Services Director (SSD) of the incident involving Resident #22 which occurred on 02/26/15.

Interview, on 05/05/15 at 5:45 PM, with LPN # 6 revealed she had worked with Resident #22 before, and reported the resident had displayed behaviors before the 02/26/15 incident which included cursing at staff if he/she did not like them. According to LPN #6, if the CNA's had reported to the floor nurse on 02/26/15, Resident #22 was displaying verbal and physical behaviors towards staff, the floor nurse should have documented the behaviors in the resident's medical record.

Interview, on 05/04/15 at 11:21 AM, with LPN #10 revealed she attended Resident #22's care conference meeting, on 03/12/15, and the resident reported a staff person called him/her the "N" word, during an exchange of name calling with the staff person. LPN #10 revealed the Social Worker (SW) took notes about the incident, and she thought this was documented somewhere in the Social Services Notes in

F 514. The Social Services will start receiving a copy of all physicians' orders each morning to review for any deletion, addition or changes in psychoactive medications and the 24 hour reports each morning for any new and or escalating behaviors and/or resident psychosocial issues that may need to be documented in the resident's medical record and care planned. The social service director will report the results of these reviews to the monthly Quality Assessment and Safety Committee meetings which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review of compliance and recommendations.

*Date of Correction:*

6-26-15

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F 514 Continued From page 131  
Resident #22's medical record, just like the nurses documented if something had happened with a resident on the floor.

F 514

Interview, on 05/05/15 at 6:15 PM, with Registered Nurse (RN) #3 revealed she was aware Resident #22 had behaviors before of making sexually inappropriate comments to female staff; however, was unaware of the 02/26/15 incident involving the resident and CNA. RN #3 revealed when the CNA's completed the Behavior Monitor form a floor nurse or evening supervisor was to review and sign the document and the nurse was to document the incident in the resident's chart.

Interview, on 05/04/15 at 12:30 PM, with RN #2/Unit Coordinator (UC) revealed the nurse assigned at the time of the 02/26/15 incident was responsible for: charting the resident's behaviors reported to him/her in the Nurse's Notes; notifying the Physician of the resident's behaviors; and documenting any orders received.

Interview, on 05/05/15 at 6:46 PM, with RN #1/UC revealed the Behavior Monitor Record form was completed by staff and reviewed by the nurse. RN #1/UC revealed the nurse was expected to then document the resident's behaviors in his/her medical record. Per interview, the Social Worker (SW) was expected to then follow-up with the resident.

Interview, on 05/03/15 at 9:15 AM, with the Social Services Director (SSD) revealed he had reviewed the Behavior Monitor Report form, dated 02/26/15, and the incident should have been documented in the resident's medical record "somewhere". Continued interview

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F 514: Continued From page 132  
revealed he was aware Resident #22's allegation was also discussed at the care conference meeting on 03/12/15, and of there being no documentation about the discussion of the incident at the care conference.

Interview, on 05/04/15 at 11:48 AM, with SW #1 revealed at the end of Resident #22's care conference meeting, on 03/12/15, the resident stated a few weeks ago there was an exchange of words between him/her and an "aide". SW #1 stated Resident #22 reported the "aide" called him/her the "N" word during the care conference. Per interview, she made a mistake not documenting what was talked about at the care conference in Resident #22's medical record. She stated however, she should have documented the care conference discussion.

Phone interview, on 05/05/15 at 7:30 PM, with the Director of Nursing (DON) revealed the Behavior Monitor Record form was used to document if when a resident had verbal and physical behaviors towards others and was signed by the supervisor nurse. The DON revealed the nurse present on 02/26/15, when the incident occurred and was reported, should have documented the incident details in Resident #22's medical record. Further interview revealed Social Services staff should have followed up with Resident #22 and documented a Note in the resident's medical record also.

Interview, on 05/05/15 at 8:10 PM, with the Administrator revealed he agreed all charted progress notes should be descriptive of the services provided and the resident's response to the services. However, he further revealed he was not a social worker or a nurse so he deferred

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F 514 Continued From page 133  
to disciplines about documentation. However, he  
acknowledged social services should follow up  
and document on the emotional status of  
residents.

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/28/2015
NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PINE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Plan approval: 1989, 1996

Survey under: NFPA 101 (2000 Edition)

Facility type: SNF/NF

Type of structure: Type V (000)

Smoke Compartments: Seven (7)

Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and basement.

Sprinkler System: Complete sprinkler system (dry).

Generator: Type 2 generator powered by natural gas installed in 1989

A Standard Life Safety Code Survey was initiated and concluded on 04/28/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred and twenty (120) beds. The census on the day of the survey was one hundred and two (102).

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

K 000



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X8) DATE: 7/8/15

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

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

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K 000 : Continued From page 1  
deficiency identified at "D" level.

K 062 : NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler systems were maintained, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) of seven (7) smoke compartments, two (2) residents, staff and visitors.

The findings include:

Observation, on 04/28/15 at 2:54 PM, with Maintenance, revealed the facility had only one (1) spare automatic sprinkler head of the pendant type. Interview, at the time of observation, with Maintenance, revealed he was unaware a minimum of six (6) spare automatic sprinkler heads were required.

Observation, on 04/28/15 at 4:00 PM, with Maintenance, revealed in the basement two (2) automatic sprinkler heads were obstructed by steel trusses. Interview, with Maintenance at the time of observation, revealed he had never identified the automatic sprinkler heads were obstructed by the steel trusses.

K 000 :

K 062 : Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.

**K 062 D**

**Residents Affected**

Upon observation it was revealed that the facility failed to have the necessary number of spare automatic sprinkler heads and that two automatic sprinkler heads in the basement were obstructed by steel trusses.

**Identification of Other Residents**

The deficiency had the potential to affect one (1) of seven (7) smoke compartments, two (2) residents, staff and visitors.

**Systemic Changes**

The Director of Maintenance, along with Administrator, have provided the appropriate amount of back up sprinkler heads as of 4-29-15. A monthly audit will be done to ensure proper number of sprinkler heads are in stock. The audit will be turned into the Administrator for review on a monthly basis.

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PRINTED: 05/29/2015  
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K 062 Continued From page 2  
The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 13 (1999 Edition)  
3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property.  
The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100°F (38°C).

5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.  
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

K 062 The Director of Maintenance relocated the two (2) sprinkler heads on 4-29-15 to a distance outside of the 18 inch radius to ensure sprinklers can deploy without obstruction.

A new QA audit was developed on 6-8-15 by the Administrator for proper storage of sprinkler heads and proper space free of obstruction for sprinkler heads. The audit includes the number of backup sprinkler heads in place. These audits are turned into the Administrator monthly for review and compliance.

**Monitoring**  
The Administrator will submit the results of the QA audits completed monthly by the Maintenance Director or designee. Quality Assurance and Safety Committee meeting for review and recommendations.

**Date of Correction:**

6-20-15

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

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K 062 Continued From page 3

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.  
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).

K 147 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure electrical panels were labeled properly, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, forty-four (44) residents, staff and visitors.

The findings include:

Observation, on 04/28/15 at 2:37 PM, with Maintenance, revealed electrical panel A did not have breakers #15 and #16 labeled properly, to indicate what the circuit breakers operated. Further observation revealed electrical panel HA did not have breaker #15 labeled properly, to indicate what the circuit breaker operated. Interview, with Maintenance at the time of observation, revealed he was not aware of what the circuit breakers operated.

Observation, on 04/28/15 at 3:01 PM, with Maintenance, revealed electrical panel HB did not have breakers #13, #14 and #15 labeled properly, to indicate what the circuit breakers operated.

K 062

K 147

**K 147 D**

**Residents Affected**  
Upon observation it was revealed that the facility failed to properly label the breaker boxes as follows: panel A, breakers #15 & 16; panel HA, breaker #15; panel HB, breakers #13, #14, & #15, failing to indicated what the circuit breakers operated.

**Identification of Other Residents**  
The deficiency had the potential to affect one residents, staff and visitors.

**Systemic Changes**  
The Director of Maintenance, along with Administrator, properly labeled the breaker boxes as follows: panel A, breakers #15 & 16; panel HA, breaker #15; panel HB, breakers #13, #14, & #15 on June 18, 2015. An audit will be completed during the annual inspection of breaker boxes. This audit will be presented to the Administrator for review.  
A new QA audit was developed on 6-8-15 by the Administrator for verifying all breaker boxes are properly labeled.

**Monitoring**  
The Administrator will submit the results of the QA audits completed monthly by the Maintenance Director. Quality Assurance and Safety Committee meeting for review and recommendations.

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PRINTED: 05/29/2011  
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K 147 Continued From page 4  
Interview, with Maintenance at the time of observation, revealed he was not aware of what the circuit breakers operated.

The findings were acknowledged by the Administrator at the exit conference.

Reference: NFPA 70 (1999 Edition)

110-22. Identification of Disconnecting Means. Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following:  
CAUTION - SERIES COMBINATION SYSTEM RATED \_\_\_\_\_ AMPERES. IDENTIFIED.  
REPLACEMENT COMPONENTS REQUIRED.  
FPN: See Section 240-83(c) for interrupting rating marking for end-use equipment.

K 147 **Date of Correction:**

6-20-15