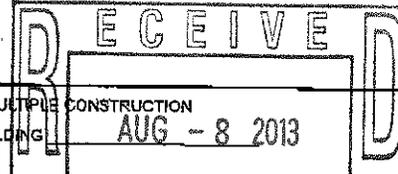


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135286	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2013
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NAME OF PROVIDER OR SUPPLIER

FAIR OAKS HEALTH SYSTEMS, LLC

Division of Health Care
STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Enforcement Branch
1 SPARKS AVENUE
JAMESTOWN, KY 42629

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	Fair Oaks Health System Plan of Action Standard Survey 7/18/13	
F 315 SS=E	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure three of twenty-three sampled residents (Residents #8, #15, and #17) received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A review of the facility's policy for indwelling urinary catheters revealed indwelling urinary catheters would be secured with a leg strap or anchor device. Observation of catheter care for Residents #8, #15, and #17 revealed the residents' indwelling urinary catheters were not secured and were draped over the residents' legs to the bedside drainage bags. In addition, while observing urinary catheter care for Resident #15, staff was observed to remove soiled gloves and</p>	F 315	<p>Preparation and execution of this plan of correction does not constitute admission 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 it is required by federal and state law.</p> <p>F 315 Urinary Incontinence Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Criteria 1: Administrative nursing observations conducted on 8/5/13 indicate that residents #8, 15, and 17 have the catheter anchored and are provided catheter care in accordance with infection control standards of practice.</p>	

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

TITLE

(X6) DATE

[Signature]

Owner/Administrator

8/7/13

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

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F 315	<p>Continued From page 1</p> <p>wipe perspiration from the staff person's own face prior to washing/sanitizing her hands.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Care of Indwelling Catheter," updated, revealed catheter care would be provided every shift and after every bowel movement. The policy revealed the facility would provide care to residents with indwelling catheters while maintaining proper infection control practices. The policy also stated staff was required to remove their gloves and wash/sanitize their hands after providing urinary catheter care.</p> <p>A review of the facility's policy titled, "Inserting A Retention Catheter," updated, revealed a urinary catheter would be secured with a leg strap or anchor device such as tape.</p> <p>A review of the facility's policy titled, "Catheter Care," updated, revealed staff was to ensure indwelling catheters were secured properly during catheter care.</p> <p>1. A review of the medical record for Resident #8 revealed the facility admitted the resident on 05/28/09 with diagnoses including Cerebral Palsy and Neurogenic Bladder.</p> <p>A review of the most recent Minimum Data Set (MDS) quarterly assessment for Resident #8 dated 06/16/13 revealed the resident had been assessed to have severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 3. The facility had assessed the resident to require total support from staff for bed mobility, transfers, locomotion, dressing, eating, personal hygiene, bathing, and toilet use (which includes</p>	F 315	<p>Criteria 2: Administrative nursing observations conducted on 8/6/13 indicate that residents with indwelling Foley catheters have the catheter anchored and are provided catheter care in accordance with infection control standards of practice.</p> <p>Criteria 3: LPN #1, RN#1, and RN#2 have received inservice education on 8/5/13 as provided by the DON (Director of Nursing), Administrator, and Director of Clinical Services on the securing of Foley catheters with anchoring devices in accordance with standards of practice.</p> <p>The licensed nursing staff have received inservice education on 8/7/13 as provided by the DON and Facility Consultant Nurse on the securing of Foley catheters with anchoring devices in accordance with standards of practice.</p> <p>State Registered Nursing Assistants (SRNA) have received inservice education on the provision of catheter care, and handwashing/changing of gloves in accordance with infection control standards of practice as provided by the DON and Director of Clinical Services on 8/1/13.</p> <p>SRNA #1, SRNA #2, and SRNA#3 have received inservice education on the provision of catheter care, and handwashing/changing of gloves in accordance with infection</p>		

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F 315	<p>Continued From page 2 managing a catheter).</p> <p>A review of the physician's orders for Resident #8 dated 07/01/13, revealed an order for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>A review of the comprehensive plan of care for Resident #8 revealed an intervention dated 04/26/11 stating staff would provide urinary catheter care.</p> <p>Observation on 07/16/13, at 4:10 PM, revealed State Registered Nursing Assistant (SRNA) #1 provided urinary catheter care for Resident #8. The SRNA was observed to position the catheter tubing over Resident #8's left leg and attach the bedside drainage bag on the side of the bed. The SRNA was then observed to place a brief on the resident. However, the SRNA failed to secure the urinary catheter tubing with tape or a leg strap.</p> <p>An interview conducted with SRNA #1 on 07/18/13, at 1:35 PM, revealed she had been trained regarding catheter care by the facility. The SRNA stated she was aware she should have either used tape or a leg strap to secure the urinary catheter and did not know why she had not.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 07/18/13, at 2:15 PM, revealed she was the Unit Manager for the C and D Wings of the facility, and made rounds several times daily to ensure staff provided care to residents to meet their needs. The LPN stated she had not monitored urinary catheter care because the SRNAs had successfully completed observation of their skills, including catheter care,</p>	F 315	<p>control standards of practice as provided by the DON and Director of Clinical Services on 8/1/13 and 8/6/13.</p> <p>Catheter care competency evaluations have been conducted on all State Registered Nursing Assistants (SRNA) by the DON/Administrative Nurses on 8/5/13, 8/6/13, 8/7/13, 8/11/13, 8/13/13, 8/14/13, 8/15/13, and 8/19/13.</p> <p>Catheter care competency evaluations will be conducted by the DON/Administrative Nurses annually for all State Registered Nursing Assistants (SRNA) as part of their yearly evaluation, and as chosen randomly on a quarterly basis.</p> <p>Criteria 4: The CQI indicator for the monitoring of catheter care and anchoring of the catheter will be utilized monthly X 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the DON. ** See Attachments 1A & 1B</p> <p>Criteria 5: August 20, 2013</p>	8/20/13	

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F 315	<p>Continued From page 3</p> <p>by Registered Nurse (RN) #2. LPN #1 stated staff was required to place the urinary catheter tubing over the resident's leg, ensure urine was draining, and clip the tubing to the resident's bottom sheet. The LPN stated the facility did not use anything to secure the urinary catheter to the resident to prevent pulling/trauma.</p> <p>An interview conducted with RN #2 on 07/18/13, at 2:55 PM, revealed she had completed competency skills observations, including urinary catheter care, of the SRNAs. The RN stated staff was required to use a leg strap or tape to secure the urinary catheter to prevent pulling/trauma. RN #2 stated she had observed SRNA #1 on 10/07/12. RN #2 stated she had not identified any concerns related to urinary catheter care she had observed being performed by SRNA #1.</p> <p>An interview conducted with the Director of Nursing (DON) on 07/18/13, at 4:30 PM, revealed staff was required to secure urinary catheter tubing with a leg strap or with tape. The DON stated she made rounds every day throughout the facility to ensure care and services were provided and had not identified any concerns with urinary catheter care.</p> <p>2. A review of the medical record for Resident #15 revealed the facility admitted the resident on 06/24/13, with diagnoses including End Stage Liver Cancer and Urinary Retention. The medical record also revealed Resident #15 was receiving hospice services.</p> <p>A review of the admission MDS assessment for Resident #15 dated 07/06/13 revealed the resident had been assessed to be cognitively intact with a BIMS score of 13. The facility had</p>	F 315			

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F 315	<p>Continued From page 4</p> <p>assessed the resident to require total support from staff for bed mobility, transfers, locomotion, dressing, personal hygiene, bathing, and toilet use (which includes managing a catheter).</p> <p>A review of the comprehensive plan of care for Resident #15 revealed an intervention dated 07/07/13 stating staff would provide urinary catheter care per facility policy.</p> <p>A review of the physician's orders for Resident #8 dated 07/01/13, revealed an order for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Observation of SRNA #2 providing urinary catheter care for Resident #15 on 07/18/13, at 11:35 AM, revealed at completion of the catheter care SRNA #2 left the urinary catheter tubing unsecured over the resident's right thigh, and hung the drainage bag on the bed rail. The SRNA was then observed to remove her soiled gloves, place the gloves in the trash, and then proceed to wipe perspiration from her face with her hands prior to washing/sanitizing her hands.</p> <p>An interview conducted with SRNA #2 on 07/18/13, at 1:45 PM, revealed she had attended in-services on urinary catheter care given by the facility. The SRNA stated she had never been told she was required to secure the urinary catheter tubing. The SRNA stated she was aware she should not have touched her face prior to washing/sanitizing her hands.</p> <p>An interview conducted with RN #1 on 07/18/13, at 1:55 PM, revealed she was the Unit Manager for the A and B Wings of the facility. The RN stated SRNA #2 should have used a leg strap or</p>	F 315			

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F 315	<p>Continued From page 5</p> <p>tape to secure Resident #15's urinary catheter tubing after she had completed the resident's catheter care. The RN stated SRNA #2 should have washed/sanitized her hands prior to wiping perspiration from her face. RN #1 stated she conducted observations every two hours and had not identified any concerns with handwashing or with urinary catheters being left unsecured.</p> <p>An interview conducted with RN #2 on 07/18/13, at 2:55 PM, revealed she had observed SRNA #2 providing urinary catheter care on 10/23/12 and had not identified any concerns related to the care the SRNA had provided.</p> <p>An interview conducted with the DON on 07/18/13, at 4:30 PM, revealed SRNA #2 should have secured the resident's catheter tubing to the resident with tape or a leg strap, and should not have touched her face prior to washing/sanitizing her hands after providing urinary catheter care.</p> <p>3. A review of the medical record for Resident #17 revealed the facility admitted the resident on 09/20/12, with diagnoses including Urinary Retention, Aphasia, and Dementia.</p> <p>A review of the most recent Minimum Data Set (MDS) quarterly assessment for Resident #17 dated 06/17/13, revealed the resident was assessed to have impaired cognition and unable to complete a Brief Interview for Mental Status (BIMS). The facility had assessed the resident to require extensive support from staff for bed mobility, transfers, locomotion, dressing, personal hygiene, bathing, and toilet use (which includes managing a urinary catheter).</p> <p>A review of the physician's order for Resident #17</p>	F 315			

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F 315	<p>Continued From page 6</p> <p>dated 07/01/13 revealed an order for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>A review of the comprehensive plan of care for Resident #17 revealed an intervention dated 02/23/13 stating staff would provide urinary catheter care.</p> <p>Observation on 07/18/13, at 11:20 AM, revealed State Registered Nursing Assistant (SRNA) #3 providing urinary catheter care for Resident #17. The SRNA was observed to position the catheter tubing over Resident #17's right leg and attach the bedside drainage bag on the side of the bed. Observation revealed the SRNA failed to secure the urinary catheter tubing with tape or a leg strap.</p> <p>Observation of SRNA #3 providing urinary catheter care for Resident #17 on 07/18/13, at 11:20 AM, revealed at completion of the catheter care SRNA #3 left the urinary catheter tubing unsecured over the resident's right thigh.</p> <p>An interview conducted with SRNA #3 on 07/18/13, at 1:40 PM, revealed she had attended in-services on urinary catheter care given by the facility. The SRNA stated she had been given a copy of the facility policy on catheter care, but did not remember she was required to secure the urinary catheter tubing. SRNA #3 stated she was not aware the facility had leg straps to secure urinary catheter tubing.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 07/18/13, at 2:15 PM, revealed she was the Unit Manager for the C and D Wings of the facility, and made rounds several</p>	F 315			

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F 315	Continued From page 7 times daily to ensure staff provided care to residents to meet their needs. The LPN stated she had not monitored urinary catheter care because the SRNAs had successfully completed observation of their skills, including catheter care, by Registered Nurse (RN) #2. LPN #1 stated staff was required to place the urinary catheter tubing over the resident's leg, ensure urine was draining, and clip the tubing to the resident's bottom sheet. The LPN stated the facility did not use anything to secure the urinary catheter to the resident to prevent pulling/trauma. An interview conducted with RN #2 on 07/18/13, at 2:55 PM, revealed she had completed competency skills observations, including urinary catheter care, of the SRNAs. The RN stated staff was required to use a leg strap or tape to secure the urinary catheter to prevent pulling/trauma. RN #2 stated she had observed SRNA #3 on 10/07/12. RN #2 stated she had not identified any concerns related to urinary catheter care she had observed being performed by SRNA #3. An interview conducted with the Director of Nursing (DON) on 07/18/13, at 4:30 PM, revealed staff was required to secure urinary catheter tubing with a leg strap or with tape. The DON stated she made rounds every day throughout the facility to ensure care and services were provided and had not identified any concerns with urinary catheter care.	F 315			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS		

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F 431	<p>Continued From page 8</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles. Observation of the "C/D" Wing medication room refrigerator revealed a</p>	F 431	<p>Drugs and biological use in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>Criteria 1: The multi-dose vial of insulin in the C/D med room has been replaced on 7/18/13.</p> <p>Criteria 2: Insulin vials have been inspected on 7/18/13 by Administrative Nursing/Pharmacy Consultant to determine that they are correctly dated when opened.</p> <p>Criteria 3: Medication Administration staff has received inservice education by the DON and Pharmacy Nurse Consultant to include but not be limited to: dating of multi-use meds upon opening as provided on 8/7/13.</p> <p>Criteria 4: The pharmacy consultant will inspect multi-use medications to determine that they have been correctly dated upon opening; with monthly consulting visits. The CQI indicator for the monitoring of medication storage in compliance with the regulations will be utilized monthly X 2 months, and then quarterly thereafter, under the</p>		

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F 431	<p>Continued From page 9</p> <p>multi-dose vial of Novolin R insulin labeled for Resident A, which was opened, available for use, and contained no date as to when the vial had been opened.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "Vials and Ampules of Injectable Medications," undated, revealed vials and ampules sent from the pharmacy are kept in a box or container with the label on the outside. The policy also stated a multi-dose vial of medication would contain the date the vial was opened and the initials of the first person to use the vial recorded on the vial label or on an accessory affixed for that purpose.</p> <p>Observation of the "C/D" Wing medication room refrigerator on 07/18/13, at 4:00 PM, revealed a multi-dose vial of Novolin R insulin labeled for Resident A, which was opened, available for use, and contained no date as to when the vial had been opened.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 07/18/13, at 4:05 PM, revealed staff was required to date all multi-dose vials of medication when the vials were opened. The LPN stated she was the Unit Manager for the "C/D" Wing and was responsible to check the medications three times a week (Mondays, Wednesdays, and Fridays) to ensure medications were labeled and dated when opened. The LPN stated she was not aware when the vial of Novolin R insulin had been opened.</p> <p>An interview conducted with the Director of Nursing (DON) on 07/18/13, at 4:30 PM, revealed staff was required to label, date, and initial all</p>	F 431	<p>supervision of the DON. ** See Attachment 2</p> <p>Criteria 5: August 20, 2013</p>	8/20/13	

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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 10 multi-dose vials of medication when the vial was opened. The DON stated the Unit Managers were required to monitor the medications three times a week to ensure staff was labeling, dating, and initialing medications when they were opened. The DON stated she had not identified any concerns with medications not being labeled, dated, and initialed when the vials were opened.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F 441 Infection Control The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Criteria 1: Resident # 15 is provided catheter care in accordance with infection control standards of practice, which includes changing of gloves and washing of hands between glove changes, as determined by care observations performed by the DON/Administrative Nurses on 8/5/13. Criteria 2: Residents are provided catheter care in accordance with infection control standards of practice, which includes changing of gloves and washing of hands between glove changes, as determined by care observations performed by the DON/Administrative Nurses on	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 11</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of twenty-three sampled residents (Resident #15). Observation of urinary catheter care for Resident #15 on 07/18/13, revealed facility staff failed to perform appropriate handwashing techniques after performing urinary catheter care and before wiping perspiration from the staff member's face.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "Care of Indwelling Catheter," undated, revealed the facility would provide care to residents with indwelling catheters while maintaining proper infection control practices. The policy also stated staff was required to remove their gloves and wash/sanitize their hands after providing urinary catheter care.</p> <p>A review of Resident #15's medical record revealed the facility admitted the resident on</p>	F 441	<p>8/5/13, 8/6/13, 8/7/13, 8/11/13, 8/13/13, 8/14/13, 8/15/13, and 8/19/13.</p> <p>Criteria 3: Facility State Registered Nursing Assistants (SRNA) have received inservice education on the provision of catheter care in accordance with infection control standards of practice which included but was not limited to: changing of gloves and washing of hands between glove changes, as provided by the DON and Director of Clinical Services on 8/1/13.</p> <p>State Registered Nursing Assistant #2 (SRNA #2) has received inservice education on the provision of catheter care in accordance with infection control standards of practice which included but was not limited to changing of gloves and washing of hands between glove changes, as provided by the DON and Director of Clinical Services on 8/1/13 and 8/6/13.</p> <p>Criteria 4: Catheter care observations were performed for facility SRNA's by the DON/Administrative Nurses to determine that they are providing this in accordance with infection control standards of practice.</p> <p>The CQI indicator for the monitoring of compliance with infection control standards during catheter care will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p>	

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

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F 441	<p>Continued From page 12</p> <p>06/24/13, with diagnoses including End Stage Liver Cancer and Urinary Retention. The medical record revealed Resident #15 was receiving hospice services. The medical record also revealed a physician's order dated 07/01/13 for the resident to have an indwelling urinary catheter.</p> <p>A review of the most recent Minimum Data Set (MDS) assessment for Resident #15 dated 07/06/13 revealed the resident had been assessed to require total support from staff for bed mobility, transfers, locomotion, dressing, personal hygiene, bathing, and toilet use (which included managing a catheter).</p> <p>Observation of State Registered Nurse Aide (SRNA) #2 on 07/18/13, at 11:35 AM, revealed the SRNA provided urinary catheter care for Resident #15 and after the SRNA completed the catheter care she was observed to remove her soiled gloves, placed the gloves in the trash, and then proceed to wipe perspiration from her face with her hands prior to washing/sanitizing her hands.</p> <p>An interview conducted with SRNA #2 on 07/18/13, at 1:45 PM, revealed she had attended several in-services on handwashing since being employed by the facility. The SRNA stated she was aware she should not have touched her face prior to washing/sanitizing her hands.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 07/18/13, at 1:55 PM, revealed she was the Unit Manager for the A and B Wings. The RN stated SRNA #2 should have washed/sanitized her hands after she had completed the catheter care and prior to wiping</p>	F 441	<p>**See Attachments 3A and 3B</p> <p>Criteria 5: August 20, 2013</p>	8/20/13	

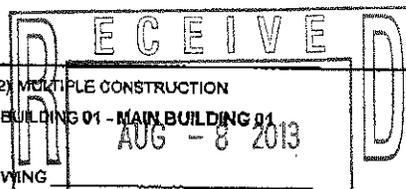
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F 441	<p>Continued From page 13</p> <p>perspiration from her face. RN #1 stated she makes rounds every two hours in the facility to observe staff providing resident care, including handwashing, and had not identified any concerns with handwashing.</p> <p>An interview conducted with RN #2 on 07/18/13, at 2:55 PM, revealed she had observed SRNA #2 performing urinary catheter care on 10/23/12 and had not identified any concerns related to handwashing.</p> <p>An interview conducted with the Director of Nursing (DON) on 07/18/13, at 4:30 PM, revealed SRNA #2 should not have touched her face prior to washing/sanitizing her hands after providing urinary catheter care. The DON stated she makes rounds throughout the facility every day and had not identified any concerns with handwashing.</p>	F 441			

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

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FORM APPROVED
OMB NO. 0938-0391



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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS South Sparks Avenue JAMESTOWN, KY 42629	CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Seven FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type 1 diesel generator A life safety code survey was initiated and concluded on 07/17/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025	K025 The facility must ensure to maintain the fire/smoke barrier wall assemblies in the attic area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Owner/Administrator	(X6) DATE 8/7/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K 025	<p>Continued From page 1</p> <p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire/smoke barrier wall assemblies in the attic area. This deficient practice affected three of seven smoke compartments, staff, and approximately twenty residents. The facility has the capacity for 114 beds with a census of 114 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/17/13, at 9:13 AM, with the Director of Maintenance (DOM), observation revealed gaps around piping in the block fire/smoke barrier wall in the attic area of the center corridor. Penetrations of fire/smoke barrier walls must be sealed with an approved material to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the DOM on 07/17/13, at 9:13 AM, revealed the DOM was aware fire/smoke barrier walls should be maintained.</p> <p>The DOM stated he was unaware this wall had</p>	K 025	<p>Criteria 1: The gaps around the piping in the block fire/smoke barrier wall in the attic area of the center corridor have been repaired with approved material by the Maintenance Supervisor on 7/30/13.</p> <p>The gaps across the ductwork and gap around penetrating electrical conduit in the B Wing attic area have been repaired with approved material by the Maintenance Supervisor on 7/30/13.</p> <p>Criteria 2: All attic smoke walls have been inspected by the Maintenance Supervisor and no further areas have been identified by 8/6/13.</p> <p>Criteria 3: The Maintenance Supervisor has received inservice from Administrator and Director of Clinical Services on the 8/5/13 on the need to inspect and maintain the attic smoke walls to assure there are no gaps or penetrations in the attic smoke walls.</p> <p>Criteria 4: The CQI indicator (ES-3) which includes the monitoring of attic smoke walls to assure there are no unsealed penetrations or gaps shall be completed by the Maintenance Supervisor monthly X 2, and then quarterly thereafter under the supervision of the Administrator. ** See Attachment 4</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 025	Continued From page 2 not been maintained. During the survey the fire/smoke barrier wall in the B Wing attic area was observed to have a gap across the ductwork and a gap around penetrating electrical conduit. The facility was cited for the same deficient practice on 04/24/12. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be	K 025	Criteria 5: August 20, 2013	8/20/13

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

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K 025	Continued From page 3 solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 025		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure the fire alarm system was being maintained according to NFPA standards. This deficient practice affected two of seven smoke compartments, staff, and approximately forty residents. The facility has the capacity for 114 beds with a census of 114 on the day of the survey. The findings include:	K 052	K052 The facility must ensure the fire alarm system was being maintained according to NFPA standards. Criteria 1: The facility contracted vendor for our fire alarm system has corrected the exit door magnetic lock system noted during the survey for the E and B wing door magnetic locks on 7/18/13. The system will no longer re-engage until the system is reset and not engage under the silent mode. Criteria 2: The facility contracted vendor for our fire alarm system along with our Maintenance Supervisor has checked all the exit doors to assure all exit doors will not re-engage when the fire alarm panel is under silent mode on 7/18/13. Criteria 3: The Maintenance Supervisor received in-service education on 8/5/13 from the Administrator and Director of Clinical Services to assure he	

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K 052	<p>Continued From page 4</p> <p>During the Life Safety Code tour conducted on 07/17/13 at 9:50 AM with the Director of Maintenance (DOM), a test of the fire alarm system revealed the E and B Wing exterior exit door magnetic locks would reengage and not release while the fire alarm system was silenced and the fire alarm panel was still showing fire conditions. The locks should not reengage until the fire alarm system is reset and showing normal conditions.</p> <p>An interview with the DOM on 07/17/13 at 10:00 AM revealed he was not aware the exit door magnetic locks were not working correctly.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NPPA 72 (1999 Edition).</p> <p>3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.</p>	K 052	<p>understands the requirements under this standard.</p> <p>Criteria 4: The Maintenance Supervisor shall complete the CQI indicator (ES-3) on a monthly basis X 2, then quarterly thereafter to assure compliance with this standard, under the supervision of the Administrator. ** See Attachment 4</p> <p>Criteria 5: August 20, 2013</p>	8/20/13