

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

PRINTED: 04/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/23/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An On-site Revisit was initiated on 04/22/15 and concluded on 04/23/15. Based on the facility's acceptable Plan of Correction, it was determined the facility was in compliance as alleged on 03/10/15.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

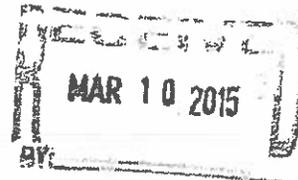
F 000 INITIAL COMMENTS

An Abbreviated/Partial Extended Survey investigating complaint KY00022713 was initiated on 01/22/15 and concluded on 02/06/15. KY00022713 was substantiated with deficiencies. Immediate Jeopardy was identified on 01/30/15 and was determined to exist on 07/27/14 at 42 CFR 483.10 Resident Rights, F-157 at a Scope and Severity of a "J"; and, 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-309; 42 CFR 483.65 Infection Control, F-441; 42 CFR 483.75 Administration, F-490 and F-520 at a Scope and Severity (S/S) of an "K". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care F-309. The facility was notified of the Immediate Jeopardy on 01/30/15.

Interview and review of Physician's Orders revealed Permethrin cream, a treatment for Scabies (a very contagious microscopic human itch mite which caused an intense itching skin irritation) was prescribed and initiated from 07/21/14 through 07/23/14, for four (4) residents. On 07/27/14, seventeen (17) additional residents were also treated with Permethrin for Scabies. However, there was no documented evidence on 07/27/14, that the facility ensured the "Scabies" Policy was followed, to include placing the seventeen (17) residents in contact isolation and performing decontamination of resident areas. In August 2014, two (2) residents were again treated for Scabies, but there was no documented evidence the Scabies Policy was followed at that time. Resident #6 was also treated on 09/10/14 with Stromectol (an oral medication for treatment of Scabies) and on 01/03/15 with Permethrin cream for Scabies.

F 000

To the best of my knowledge and belief, as an agent of Diversicare of Nicholasville, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.



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

[Handwritten Signature]
SAM FRASER

TITLE

ADMINISTRATOR

(X6) DATE

3/10/15 (APP. END)

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 Additionally, Resident #9 was treated again while hospitalized between 01/03/15 and 01/06/15 for Scabies, and again at the facility on 01/11/15. The facility failed to have a system in place to monitor the infection control program for the facility's residents to ensure the eradication of the Scabies and to ensure the decontamination of the facility. Additionally, the facility failed to ensure the implementation of the "Scabies" policy regarding treatment and precautionary measures to be taken to ensure eradication of the Scabies which resulted in continued rashes, itching and discomfort for the facility's residents. Observation, on 01/22/15, revealed multiple residents scratching their bodies, with several residents observed to have dark reddish blood-like spots on their clothing and bed linens. Continued observation revealed no residents were in contact isolation, as per facility policy. Also, observations during skin assessments for fifteen (15) of the sixteen (16) sampled residents revealed all had rashes of varying degrees on their bodies. An acceptable Credible Allegation of Compliance (CAOC) was received on 02/05/15, which alleged removal of the Immediate Jeopardy on 02/05/15. On 02/06/15, the State Survey Agency verified the Immediate Jeopardy was removed on 02/05/15 as alleged with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157 at a S/S of a "D"; and 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-309; 42 CFR 483.65 Infection Control, F-441; 42 CFR 483.75 Administration, F-490 and F-520 at a S/S of "E" while the facility develops and implements the Plan of Correction (POC) and the facility's	F 000			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 Quality Assurance monitors the effectiveness of the systemic changes.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157	F157 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #16 identified to have been found affected by the deficient practice. After physician notification and subsequent order on 2/4/15, Resident #16 was accompanied by center staff (Activities Director) to a dermatology appointment on 2/4/15. Documentation in nurses' notes dated 2/4/15 support family notification of appointment and subsequent treatment orders. Resident #16 discharged to home as planned with plan of care of 2/5/15. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. After review of all residents with rash it was determined notifications were present.	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157	Continued From page 3 by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure the Physician and the legal representative were notified when one (1) of sixteen (16) sampled residents exhibited signs and symptoms of itching and scratching and complained to staff (Resident #16). Interview and record review revealed a treatment for Scabies (a very contagious microscopic human itch mite which caused an intense itching skin irritation) was prescribed and initiated from 07/21/14 through 07/23/14, for four (4) residents. On 07/27/14, nine (9) more residents were also treated for Scabies. However, there was no documented evidence on 07/27/14 the facility ensured the "Scabies" Policy was followed to include placing the nine (9) residents in contact isolation and performing decontamination of resident areas. Immediate Jeopardy was identified on 01/30/15 and was determined to exist on 07/27/14. The facility was notified of the Immediate Jeopardy on 01/30/15. Interview and record review during the Partial/Extended Survey on 02/04/15, revealed Resident #16 reported itching for about two (2) weeks, and stated it felt just like it did when the resident had scabies in 1957. Despite the fact there were confirmed cases of scabies in the facility, and Resident #16's spouse resided on the unit where all residents were treated, the facility failed to report the resident's symptoms to the physician until after State Survey Agency intervention. The facility's failure to have an effective system in place to ensure the Physician and the legal	F 157	What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? An in-service was conducted on 1/28/15 by the Director of Nurses for all licensed nursing staff that included education on physician and family/responsible party in regards to an identified resident change of condition. On 2/6/15, the Director of Nursing did a repeat education to all licensed nursing staff in regards to accurate coding of skin assessments; that included requirements of physician and family notification. The nursing 24 hour report and prior day physician orders are reviewed each weekday morning in Clinical Start Up meeting that is attended by the Administrator, Director of Nursing, Minimum Data Set Supervisor (MDS), Social Services, Business Office Manager, Staff Development Coordinator and Dietary Manager, to ensure that the follow up measures have been implemented to include physician and responsible party notification. This meeting is led by the Director of Nursing Services or member of the nursing leadership team. The	
-------	---	-------	---	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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)	
F 157	<p>Continued From page 4</p> <p>representative were notified of a change in status or of a need for treatment was likely to cause serious injury, harm, impairment or death to a resident.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 02/05/15, with the facility alleging removal of the Immediate Jeopardy on 02/05/15. The State Survey Agency verified removal of the Immediate Jeopardy on 02/05/15 as alleged, prior to exit on 02/06/15, with remaining non-compliance at Scope and Severity of an "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance program monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Notification of Changes", effective date 08/01/12, revealed the licensed nurse was to notify the Attending Physician and the resident's legal representative when a change in health status occurred. Continued review revealed the change exhibited by the resident and the date and time of the notification(s) were to be documented in the Nurses Notes.</p> <p>Review of the clinical record revealed Resident #16 was admitted to the facility on 01/16/15 for rehabilitation after a fall at home. Review of the Brief Interview for Mental Status (BIMS), dated 01/23/15, revealed the facility assessed Resident #16 to have a score of fifteen (15) which indicated the resident was cognitively intact and interviewable.</p> <p>Interview with Resident #16, on 02/04/15 at 8:05</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 5
AM, revealed the resident reported itching on his/her back for about two (2) weeks. Continued interview revealed the resident did report the itching to staff, but was not aware of any new treatment orders. The resident stated a nurse put some lotion on the itch but it only helped for a short time.

Interview with Licensed Practical Nurse (LPN) #6, on 02/05/15 at 5:00 PM, revealed Resident #16 had asked for lotion to be applied to his/her back almost every night, but had only complained of itching about three (3) times. Continued interview revealed LPN #6 did not notify the Physician because the resident's spouse, who was also a resident at the facility, reported Resident #16 scratched at home, too.

Observation of a skin assessment conducted by LPN #2, on 02/04/15 at 9:58 AM, revealed Resident #16 had red linear abrasions on the left lower back. In addition, the resident exhibited a raised red rash in clusters on the upper back, neck and both shoulders. Continued observation revealed a scabbed area behind the right ear. At the time of the skin assessment, Resident #16 stated he/she had been scratching the lower back area where the abrasions were noted. The resident further stated he/she wasn't able to reach all the places that itched, so the resident had to stand and scratch his/her back by rubbing it against the doorway. The resident further reported having been infected with scabies in 1957, and stated the current itching felt just like that.

Interview with LPN #2 after the skin assessment, on 02/04/15 at 10:50 AM, revealed Resident #16 did not have a Physician's order for anti-itch

F 157 weekend RN Supervisor is assigned to follow up with all changes in condition to ensure physician and responsible party notification, as well as with any new orders that may result. A comprehensive review of the 24 hour report and prior day physician orders for Friday through Sunday are completed in Monday's Clinical Start-Up meeting as referenced above. The Clinical Start-Up is an on-going process that allows for monitoring of the medical record to ensure that applicable notifications have been completed.

How will the facility monitor performance to ensure solutions are sustained? Any identified issues with physician and/or responsible party notification not completed timely or as educated will be addressed upon discovery with the appropriate staff member, with re-education and will be followed monthly in the facility Quality Assurance Process Improvement (QAPI) meeting that consists of and attended by the Administrator, Director of Nursing, MDS Coordinator, Staff

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 6</p> <p>medication. During subsequent interview, on 02/04/15 at 2:01 PM, LPN #2 stated she did not notify the Physician of the resident's complaint of itching, but reported to "management" that Resident #16 had self-inflicted scratches. She further stated she could not remember exactly who in "management" she reported to, but she assumed they would take care of obtaining orders.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #8, on 02/05/15 at 4:45 PM, revealed Resident #16 had complained of itching for about two (2) weeks. She stated she told the Director of Nursing (DON) about the resident's complaint, but could not remember when she told her.</p> <p>Interview with SRNA #13, on 02/06/15 at 4:22 PM, revealed she was aware Resident #16 had complained of itching to her while she was providing care. She stated it was at least one (1) week ago, but may have been two (2) weeks ago. Continued interview revealed she reported it to the nurse but could not remember which nurse she reported to.</p> <p>Interview with the DON, on 02/05/14 at 12 50 PM, revealed she had seen one (1) "scratch" on Resident #16's lower back but could not remember what day it was. She stated she had reviewed the resident's documented skin assessment dated 02/02/15 which indicated Resident #16 had "self-inflicted" scratches. The DON reported she acted on the premise that Resident #16 had a history of picking and scratching, and did not take it any further. Continued interview revealed the DON did not have any conversation with any staff regarding Resident #16's "scratches", and was not aware</p>	F 157	<p>Development Coordinator, Medical Records Director, Activity Director and Social Services Director, Housekeeping/Laundry Supervisor, Maintenance Supervisor, Business Office Manager and Dietary Manager. The Medical Director and consulting pharmacist attend the QAPI meeting quarterly, at a minimum. The members of the QAPI Committee will make recommendations regarding further monitoring and continued compliance.</p>	3/16/15

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 7
the resident had complained of itching. However, further interview revealed the DON thought perhaps Resident #16 was itching and scratching due to some of his/her medication. The DON further stated staff should have used critical thinking skills in order to determine the underlying cause of the resident's discomfort, and the itching and scratching should have been reported to the Physician and treatment orders obtained, regardless of the cause of the symptoms.

Interview with the Power of Attorney (POA) for Resident #16, on 02/04/15 at 6:58 PM, revealed she was not notified of the resident's itching and scratching until the day of this interview, 02/04/15. She stated the resident did not have a history of scratching and digging at his/her skin, and had not had a rash the POA was aware of.

Further review of the clinical record revealed no documented evidence the Physician was notified of Resident #16's symptoms until 02/04/15, after State Survey Agency intervention. Review of the Physician's Order, dated 02/04/15, revealed Resident #16 was to have a Dermatology appointment scheduled and was to receive Benadryl, 25 mg every six (6) hours as needed for itching. Continued review revealed an order for initiation of scabies treatment, including Elimite cream, Stromectal tablets, disinfection of the resident's room and personal belongings, and initiation of contact isolation procedures.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 02/05/15 which alleged removal of the IJ effective 02/05/15. Review of the AOC revealed the facility implemented the following:

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 8 1. On 01/26/15, the Medical Director and the Director of Nursing (DON) assessed ten (10) residents identified to have current treatment orders for a change in skin condition. 2. On 01/26/15, body audits were completed on all in-house residents by an RN and a LPN. Based on the skin assessments, the Medical Director gave verbal orders for STAT (Immediate) dermatology appointments for three (3) of the residents. Appointments were made for the same day. Two (2) of the three (3) residents (Residents #1 and #10) were confirmed to have scabies. 3. On 01/26/15, the Medical Director was notified of the positive for results and orders were given to treat all thirty-one (31) residents on the B-wing for scabies. The orders included the following for all of the residents: contact precautions; Elimite cream to be applied beginning 01/27/15 and repeated in seven (7) days; and Stromectol tablets to be administered on day 1, 2, 8, 9, and 15 of the treatment process. The Responsible Party for all residents on the B wing was notified of the treatment orders by the Assistant DON (ADON) or the Activities Director. 4. On 01/26/15, all B wing residents were placed on contact isolation per the facility's guidelines. The DON, Director of Clinical Operations (DCO), Administrator and the Housekeeping/Laundry supervisor placed signs on all resident doors and on entrance doors. Personal Protective Equipment (PPE) was distributed and each department was notified of the precautions in place.	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 9

5. On 01/26/15, the DCO educated the DON and the Administrator related to scabies in long term care facilities, including prevention and control. The training included a review of the "Scabies Fact Sheet". The DON and the Administrator were educated by the DCO prior to proceeding to train all facility staff.

6. On 01/26/15, the Administrator and the DON initiated education for all staff related to contact isolation procedures, including the appropriate application and removal of PPE. Staff was required to complete the education prior to returning to work, with validation of effective learning through observation of staff adherence to isolation procedures and proper use of PPE.

7. On 01/26/15, an emergency Quality Assurance (QA) meeting was held and attended by the Administrator, DON, DCO, Housekeeping/Laundry Supervisor, Staff Development Coordinator (SDC) and the Medical director. The purpose of the meeting was to review the actions taken by the facility beginning 01/26/15.

8. On 01/27/15, all B wing residents were treated with Elimite cream, with application of the treatment by licensed nursing staff. The cream was left on for eight (8) to fourteen (14) hours before residents were bathed and dressed in clean clothes. The baths/showers were provided by the State Registered Nursing Assistants (SRNAs) and the LPN on duty, and the entire process was overseen by two (2) RNs.

9. On 01/27/15, all B wing residents received their first dose of Stromectol dose, as ordered by the Physician, administered by the LPN.

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 10 10. On 01/27/15, the Housekeeping/Laundry Supervisor provided training for all laundry and housekeeping staff related to cleaning of contaminated isolation rooms, per facility guidelines. 11. On 01/27/15 all linen items, including personal clothing, bed linens and privacy curtains were removed from each resident room on the B wing by laundry staff. The linens were washed separately from other residents in the facility using hot water and hot dryer cycles. The laundry machines were disinfected with bleach germicidal cleaner. All non-washable personal belongings were placed in sealed bags or wrapped in plastic wrap and quarantined outside the center, where they are to remain for fourteen (14) days per facility guidelines. The entire process was overseen by the Housekeeping/Laundry Supervisor. 12. On 01/27/15, furniture and equipment throughout the facility, including the common areas on both wings and the dining room, was disinfected with the bleach germicidal cleaner by housekeeping staff and monitored by the Housekeeping/Laundry Supervisor. 13. On 01/27/15, the Administrator contacted the local health Department by telephone and via e-mail to report the diagnosed scabies, rashes and treatment. 14. On 01/27/15, the Minimum Data Set (MDS) Coordinator revised the Care Plan for each resident receiving treatment. The revisions included the current problem related to scabies treatment, isolation precautions, treatment of	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 11
itching, and monitoring for treatment side effects.

F 157

15. On 01/27/15, the option for treatment was provided to each employee of the facility. The DON began distributing Elimite cream on 01/27/15 along with verbal instructions. The DON is maintaining a log of staff who accepted treatment. On 02/03/15, the DON distributed a questionnaire to staff to determine if the treatment was effective and if staff continued to have symptoms and required additional treatment.

16. On 01/28/15, two (2) residents on the A wing began treatment for a rash identified on review of the skin audits by the DON. Treatment included contact isolation, application of Elimite cream with repeat application in one (1) week, and Stromectal tablets to be administered on day 1, 2, 8, 9 and 15. Resident rooms, clothing, personal items and equipment were cleaned per facility protocol.

17. On 01/28/15, the DON educated all licensed staff on accurately completing a skin assessment. The DON will oversee five (5) skin inspections weekly for six (6) weeks to ensure accuracy of assessment and competency of licensed staff. Any discrepancy will be immediately addressed and the nurse will be re-educated.

18. On 01/30/15, the Administrator and the DON initiated training on the "Scabies Fact Sheet" and the "Guidelines for Scabies" through handouts and discussion. The education for all staff to be completed by 02/04/15. Beginning 02/04/15, written post-tests were initiated for all departments to ensure staff retention of knowledge related to the training. Thirty (30)

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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 157	<p>Continued From page 12</p> <p>post-tests will be administered weekly for six (6) weeks and then monthly for six (6) months to ensure continued compliance. Any staff unable to complete the post-test with 100% accuracy will receive immediate re-education by the DON, Administrator or RN supervisor. Also beginning, 02/04/15, the "Scabies Fact Sheet" will be included in new employee orientation and annual infection control in-services. Any staff on leave and any agency staff will receive the education and complete the post-test prior to a return to work.</p> <p>19. On 01/30/15, the DCO in-serviced the DON on infection control surveillance logs, tracking and trending for scabies or other rashes, and the need for ongoing monitoring. The proper use of the "Scabies/Rash Tracking Log" and the "Skin Inspection Log" was included in the training.</p> <p>20. On 01/30/15, the DCO educated the MDS Coordinator related to ensuring the Care Plans related to scabies/rashes included the specific problem, goal, and interventions for ongoing monitoring.</p> <p>21. Evaluation and monitoring of each resident receiving treatment will included skin inspections for resolution of rashes, and observation for new skin eruptions in two (2) to six (6) weeks per Centers for Disease Control (CDC) guidelines. Skin inspections will be completed by licensed staff on all residents in the facility twice weekly beginning 01/31/15 for seven (7) weeks and weekly thereafter. The Physician will be notified of any findings and treatment will be initiated per Physician orders. Residents treated will be monitored for response to treatment and the presence of any treatment side effects.</p>	F 157	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 02/06/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157	<p>Continued From page 13</p> <p>22. On 01/31/15, a QA meeting was held with the Administrator, DON, Regional Vice President (RVP), DCO and the Medical Director to re-evaluate all measures implemented since 01/26/15, and to outline action items moving forward.</p> <p>23. As of 01/31/15, daily corporate oversight will occur until removal of abatement of the Immediate Jeopardy, then weekly for at least seven (7) weeks to ensure continued compliance of Administration.</p> <p>24. On 01/31/15, the facility established a "Scabies Prevention and Control Plan" which included the following: implementation of the "Scabies Guidelines" based on CDC guidelines; promotion of a high index of suspicion for scabies as a possible cause of undiagnosed skin rash; and referral to a Dermatologist after a failed initial course of treatment.</p> <p>25. On 02/03/15, the Responsible Party for each A wing resident was notified by phone by the ADON or the Activities Director of a scabies outbreak, with messages left for those parties who did not answer.</p> <p>26. On 02/04/15, the Medical Director gave orders to initiate treatment on all remaining residents on the A wing. Treatment orders were the same as for all other residents in the building, and included disinfection of resident rooms, clothing, personal items and equipment. In addition, common areas were cleaned according to facility guidelines.</p> <p>27. Residents #1 and #10, with confirmed scabies</p>	F 157		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157	<p>Continued From page 14</p> <p>diagnoses, will have a follow-up appointment with the Dermatologist on 02/06/15. The DON or the RN will accompany the residents to the physician's office.</p> <p>28. The facility's QA process will monitor implemented interventions as follows:</p> <p>The Administrator, DON or RN Supervisor will review the "Scabies/Rash Tracking Log" daily for six (6) weeks, then weekly for four (4) weeks, then monthly in the Quality Assurance/Process Improvement (QAPI) meeting.</p> <p>The Administrator, DON or RN Supervisor will review the "Skin Inspection Log" daily for six (6) weeks, then weekly for four (4) weeks, then monthly in the QAPI meeting.</p> <p>The Administrator, DON or RN Supervisor will review the Care Plans of residents being treated for scabies weekly for eight (8) weeks, then monthly in the QAPI meeting.</p> <p>The Administrator and/or the DON will ensure all staff has successfully completed the training and post-test related to the facility's "Scabies Prevention and Control Plan".</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the Physician Extended Care Notes, dated 01/26/15 and signed by the Medical Director, revealed the ten (10) residents with treatment orders for a change in skin condition on that date were seen by the Physician for a complete physical examination and evaluation of their skin concerns. Continued review revealed each examination was comprehensive and</p>	F 157		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 15
included documentation by the Physician of each resident's skin and recommended treatment.

2. Review of the "Body Audit" forms, dated 01/26/15 and signed by the RN or the LPN, revealed sixty-five (65) residents in the facility received a head-to-toe skin assessment on that date. Continued review revealed each resident was assessed for eleven (11) specific skin conditions as follows:
redness/discoloration/bruises; open areas; edema; rash; dry/flakey; excoriation; ecchymosis; skin tears; abrasions; surgical wounds or incisions; and psoriasis. Findings were documented by type and location.

Review of the Dermatologist's "Visit Notes", dated 01/26/15, revealed three (3) residents were seen in the office on that day. Continued review revealed two (2) of the three (3) residents (Residents #1 and #10), based on microscopic examination, were found to be positive for scabies and treatment orders were given. Additionally, the resident who did not have a confirmed diagnosis was treated prophylactically due to the resident's possible exposure to scabies.

3. Review of the Physician Orders, dated 01/26/15, revealed the Medical Director gave orders for scabies treatment to be initiated on 01/27/15 for all residents on the B wing. Continued review revealed the orders were consistent with those given by the Dermatologist for the confirmed cases, with treatment to be administered as follows: apply Permethrin (Elimite) 5% cream to body from neck down, leave on 8-14 hours then wash off; repeat in one (1) week; after cream applied, administer

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 16</p> <p>Stromectal, 3 milligram (mg) tablets on day 1,2,8,9, and 15. In addition, Physician Orders included direction for contact isolation, dry skin lotion, and Benadryl PRN (as needed) for itching, for each resident.</p> <p>Review of Departmental Notes, dated 01/27/15, revealed the Responsible Party for each resident on the B wing was notified of the new orders by the Activities Director or the ADON.</p> <p>Interview with the ADON, on 02/04/15 at 2:02 PM, revealed she had made calls to the families of the B wing residents, informing them of new treatment orders and contact isolation procedures. She stated some families had questions and she answered as they arose.</p> <p>Interview with the POA for Unsampled Resident J, on 02/04/15 at 6:58 PM, revealed she was notified by the facility of treatment orders and isolation procedures for all residents on the B wing, including Resident J.</p> <p>4. Observation upon entering the facility, on 01/28/15 at 4:01 PM, revealed signs directing visitors to see the nurse prior to visiting with residents were posted on the front entrance doors and on the door of each resident room on the B wing. In addition, the signs on resident room doors indicated Contact Isolation was in effect. Continued observation revealed PPE, including gowns, masks, gloves and shoe covers, was stocked in bins in the hall outside resident rooms on the B wing. During survey activities throughout the day on 01/26/15, staff from all departments was observed to utilize the PPE prior to entering resident rooms. Also, staff was observed to dispose of PPE appropriately, in</p>	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 17
biohazard containers inside resident rooms, upon exit from the room.

5. Review of training record signatures revealed the DCO provided training to the Administrator and the DON on 01/26/15. The in-service was titled "Scabies in Long Term Care" and utilized the "Scabies Fact Sheet", for education related to the prevention and control of scabies in the long term care setting. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed she educated the Administrator and DON to ensure they were knowledgeable about managing a scabies outbreak, prior to their training of the rest of the staff, in order for all education to be consistent and according to facility guidelines.

Interview with the DON on 02/05/15 at 12.50 PM, and the Administrator on 02/06/15 at 2:45 PM, revealed both received training from the corporate DCO related to scabies infestation. Continued interview revealed the training by the DCO occurred prior to the Administrator and the DON educating the staff.

6. Review of training records revealed, on 01/26/15, the Administrator and the DON initiated education for all staff related to Isolation Precautions, with emphasis on contact precautions. Review of training materials revealed the education included the proper use of PPE. Further review of in-service sign-in sheets revealed eighty (80) of eighty (80) staff had received the mandatory training on or before 01/30/15.

Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:56 PM, SRNA #23 on 01/29/15 at

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 18</p> <p>2:04 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #8 on 01/29/15 at 4:37 PM, RN #2 on 01/29/15 at 4:38 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA #11 on 01/30/15 at 3:35 PM, SRNA #24 on 01/30/15 at 3:55 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, Wound Care Nurse on 02/04/15 at 3:20 PM, RN #1 on 02/05/15 at 4:30 PM, LPN #6 on 02/05/15 at 4:55 PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Worker #26 on 02/06/15 at 2:00 PM, Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, and Laundry Worker #25 on 02/06/15 at 6:20 PM, revealed all had received training related to isolation precautions. During the interviews, all were able to express the appropriate PPE required for contact isolation.</p> <p>Interview with the DON on 02/05/15 at 12:50 PM, and the DCO on 02/05/15 at 2:45 PM, revealed in addition to the eighty (80) "active" staff, three (3) staff members were currently on leave. Continued interview revealed the DON was responsible for scheduling and was tracking those staff members to ensure they were in-serviced prior to returning to work. Further interview revealed the facility had used Agency staff on occasion and notification was sent to the Agency of the required in-servicing prior to any further scheduling of Agency staff. In addition, the DON was tracking to ensure no Agency staff worked without receiving the education. She stated no Agency staff had worked at the facility since the in-services were initiated.</p> <p>Observations, on 01/28/15 at 11:30 AM and on</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157	<p>Continued From page 19</p> <p>02/05/15 at 4:00 PM, revealed the Administrator, the DON and the Housekeeping Supervisor were on the resident units, observing staff and monitoring availability and proper use of PPE.</p> <p>7. Review of QA records revealed an "Emergency" meeting was held on 01/26/15 at 7:30 PM, and was attended by the Medical Director, the DCO, the Administrator, the DON, the Assistant DON and the Housekeeping Supervisor, as evidenced by their signatures. Meeting attendees reviewed the confirmed cases of scabies, and recommendations from the Medical Director to treat all residents on the B wing, and to offer and encourage treatment to staff. Other items discussed included the initiation of Contact Precautions, body audits of all residents, cleaning and disinfection of resident rooms and common areas, and the prescribed treatment for the B wing residents.</p> <p>Interview with the Administrator, on 02/06/15 at 2:45 PM, revealed the Medical Director had been present and very involved in developing and implementing the facility's action plan to remove the Immediate Jeopardy. He stated although it was not in the QA minutes, he had a conversation with the Medical Director whose stated intent was to complete a re-assessment of every resident in the facility once the treatment was completed.</p> <p>8. Review of the Medication Administration Records for the B wing residents revealed all were treated with Elimate cream on 01/27/15. Continued review revealed the cream was applied by licensed nursing staff.</p> <p>Review of the facility's schedule for applying the cream and subsequent showering of each</p>	F 157		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 20</p> <p>resident revealed a minimum of eight (8) hours elapsed between application and removal of the cream.</p> <p>Interviews with RN #2 on 01/29/15 at 4:35 PM, SRNA #18 on 01/31/15 at 2:47 PM, RN #1 on 02/05/15 at 4:30 PM, SRNA #4 on 02/05/15 at 4:38 PM, and SRNA #15 on 02/05/15 at 6:04 PM, revealed they had been involved in application of the Elimate cream and removal by bath or shower eight (8) to fourteen (14) hours later. The interviewees described the process whereby the cream was applied on one shift, and washed off on the next shift, following the same order of residents, according to the schedule. RN #1 and RN #2 reported they were responsible for applying the cream, and ensuring it was bathed off by the SRNAs, providing assistance if needed. The SRNAs stated they assisted the nurse with positioning during application of the cream, but their primary job was to bathe or shower the residents after at least eight (8) hours had passed.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed the RN or LPN on duty on the shift the cream was applied, and on the shift when removed, was responsible for overseeing the process. Continued interview revealed the DON took ultimate responsibility for ensuring each resident was treated appropriately, according to the Physician's orders. She stated she monitored the process by reviewing the MARs, interviewing staff and residents, and making observations of the application and removal of the cream.</p> <p>9. Review of the MARs for the B wing residents revealed all were administered Stromectal tablets, according to the Physician orders, on</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157

Continued From page 21
01/27/15.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed her oversight of the treatment process included a review for timely administration of the Stromectol.

10. Review of training records revealed the Housekeeping Supervisor provided education to eight (8) of eight (8) housekeeping and laundry staff on 01/27/15. Continued review revealed the education included the proper handling of trash and linens, cleaning and disinfecting of horizontal surfaces, walls, furniture and bathrooms, dust mopping and damp mopping, and proper disposal of trash and transport of linens to be laundered.

Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 02/19/15 at 1:56 PM, Housekeeping Staff #12 on 01/29/15 at 2:07 PM, and Housekeeping Staff #11 on 01/29/15 at 2:19 PM, revealed all received training related to "deep cleaning" of contaminated isolation rooms. All interviewees were able to answer specific questions related to topics covered in the in-service, including the types of disinfectants to be used, as well as the process to be followed.

Interview with the Housekeeping Supervisor, on 01/29/15 at 4:47 PM, revealed he had in-serviced his staff on 01/27/14 related to the procedure for cleaning and disinfecting the isolation rooms after an outbreak of scabies. He stated the process required a team effort and his role was to ensure his staff was educated, and to oversee the cleaning to ensure all steps were followed properly.

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 22</p> <p>11. Observation, on 01/28/15 at 11:30 PM revealed staff was in the process of decontaminating all resident linens, including personal clothing, bed linens and privacy curtains on the B wing. Linens had been transported to the laundry area on 01/27/15 for laundering using hot washer and dryer settings. Continued observation revealed resident room were cleaned and disinfected while the residents were out of the rooms for their baths or showers. All washable surfaces were disinfected with a bleach product, according to the facilities "Scabies Guidelines". No non-washable items, including cloth furniture, were observed anywhere in the facility, including resident rooms and common areas. The Housekeeping Supervisor was observed to be actively participating and overseeing the process. In addition, housekeeping staff were observed to be utilizing PPE during the cleaning.</p> <p>Interview with Laundry Worker #25, on 02/05/15 at 5:30 PM, revealed she was responsible for laundering contaminated linens during her shift. She stated the linens arrived in the laundry area in red biohazard bags. She further stated the linens were removed from the bags and placed directly in the washer for laundering in hot water, followed by drying on the hot cycle for at least twelve (12) minutes. Continued interview revealed the process was followed for residents' personal clothing, bed linens, privacy curtains, "anything washable". Further interview revealed the washers and dryers were disinfected with a bleach disinfectant between uses.</p> <p>12. Interview with the Housekeeping Supervisor, on 01/28/15 at 11:30 AM, revealed all furniture and equipment in common areas throughout the</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157 Continued From page 23
 building was disinfected on 01/27/15. He stated the resident rooms, including washable furniture were being cleaned on 01/28/15 while residents were out of their rooms for bathing. He further explained all personal clothing, linens and privacy curtains had been removed prior to bathing to ensure the room was decontaminated prior to the residents returning. Continued interview revealed all cloth furniture and any items which could not be disinfected had been wrapped in plastic, removed from the building, and were stored in an outbuilding for the next fourteen (14) days, per the facility's "Scabies Guidelines".

13. Review of e-mail correspondence, dated 01/27/15 at 9:40 AM, revealed the Administrator contacted the local Health Department and reported two (2) confirmed cases of scabies and the facility's decision to treat all residents on that unit. Continued review revealed the e-mail referenced an earlier voice mail left with the Health Department related to the same report.

Review of Health Department documents revealed the facility received general information related to scabies and the "Scabies Fact Sheet" in response to their report.

14. Review of the Care Plans for fifteen (15) selected residents who were treated for scabies revealed a new care plan was developed for each resident on 01/26/15. Continued review revealed the Care Plans included the following: the problem of risk for scabies exposure; stated goals to identify and promptly treat any rashes, have no complications related to the rash; and have resolution of the rash; and interventions directed to addressing the problem and meeting the goals. Interventions included specific

F 157

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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 157	Continued From page 24 treatment orders, contact isolation, cleaning of resident rooms and belongings, monitoring of skin, monitoring for side effects of the medication, comfort measures including PRN (as needed) medications for itching and dry skin, and notification of the Physician as indicated by resident assessments and response to treatment. 15. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed all staff were offered the option to receive treatment for scabies. She stated the DON was tracking those employees who did accept treatment. Continued interview with the DCO revealed questionnaires were distributed to all staff on 02/03/15 to determine if staff with symptoms had been treated and if treatment was effective. Review of the log maintained by the DON revealed fifty-one (51) employees accepted treatment. Review of the completed questionnaires revealed fifty-one (51) had been returned as of 02/03/15. Three (3) additional completed questionnaires were submitted by staff on 02/06/15. Continued review revealed the questionnaires addressed the presence of symptoms of a rash in the past sixty (60) days, whether treatment had been accepted and if it was effective, whether staff required repeat treatment or now desired to accept treatment for the first time, and whether staff needed additional education related to scabies. Interview with the DON, on 02/06/15 at 1:50 PM, revealed she had provided the Elimate cream to every staff member who requested it. She stated staff were educated on the symptoms of scabies and offered treatment during the training process.	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 157	<p>Continued From page 25</p> <p>Continued interview revealed the questionnaires were designed to ensure the treatment was effective for those staff who accepted it, and to determine if there were other staff experiencing symptoms or desiring treatment.</p> <p>Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:56 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #8 on 01/29/15 at 4:37 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, RN #1 on 01/30/15 at 3:20 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA #11 on 01/30/15 at 3:35 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, LPN #1 on 02/04/15 at 2:10 PM, SRNA #4 on 02/05/15 at 4:38 PM, LPN #6 on 02/05/14 at 5:00 PM, SRNA #15 on 02/05/15 at 6:04 PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Staff #26 on 02/06/15 at 2:00 PM and Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, revealed all had been offered treatment with Elimite cream for scabies, for symptoms of a rash/itching or prophylactically. All staff stated they were trained on scabies and how to use the cream if desired.</p> <p>16. Review of Physician orders for 01/28/15 revealed on the A wing, Resident #13 and his/her roommate who was not sampled, were to receive scabies treatment, including the Elimite cream to be applied on day 1 and repeated in one (1) week, and Stromectol tablets to be administered on day 1, 2, 8, 9 and 15. In addition, the residents were to be placed on contact isolation precautions.</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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 157	<p>Continued From page 26</p> <p>Review of the MAR for Resident #13 revealed treatment was initiated as ordered.</p> <p>Interviews with Housekeeping Staff #11 on 10/29/15 at 2:19 AM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #6 on 01/29/15 at 4:37 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, LPN #2 on 01/30/15 at 3:43 PM, and SRNA #10 on 01/30/15 at 3:55 PM revealed Resident #13 and his/her roommate were in contact isolation, their room had been cleaned and disinfected and personal clothing, bed linens and privacy curtains had been bagged for laundering.</p> <p>17. Review of training records revealed the DON provided education to all licensed nursing staff related to completing a head-to-toe skin assessment on 01/28/15. Review of the training outline revealed topics covered included how and when skin assessments were to be completed, documentation of findings, and required notifications to family and Physician. Continued review revealed a question and answer session was provided and additional individual training was offered to all nursing staff.</p> <p>Interviews with RN #1 on 01/30/15 at 3:20 PM, LPN #2 on 01/30/15 at 3:43 PM, LPN #1 on 02/04/15 at 2:10 PM, and LPN #6 on 02/05/14 at 5:00 PM, revealed they had attended an inservice with the DON on 01/28/15 related to accurately performing a resident skin assessment. Continued interviews revealed the licensed staff were able to verbalize when skin assessments were to be completed, how to document their findings, and when and to whom notifications regarding the skin assessments were to be made.</p>	F 157	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 27</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed she would be monitoring five (5) skin assessments on the units weekly for six (6) weeks. She stated any identified problems observed would be addressed by immediate re-education.</p> <p>18. Review of training records revealed the Administrator and the DON initiated training for all staff related to scabies. Educational handouts included the "Scabies Fact Sheet" and the "Guidelines for Scabies". Review of these documents revealed they were comprehensive in describing symptoms, treatment and monitoring for response. In addition, information included the accepted process for handling laundry and cleaning and disinfection of rooms. Emphasis was on preventing spread of the infestation in an institutional setting.</p> <p>Review of sign-in sheets revealed eighty (80) of eighty (80) staff received the education by 02/04/15. Three (3) staff were on leave and were required to complete the education prior to returning to work.</p> <p>Interview with the DON, on 02/05/15 at 12:50 PM, revealed she was responsible for scheduling and was tracking the staff members on leave to ensure they were in-serviced prior to returning to work. Further interview revealed the facility had used Agency staff on occasion and notification was sent to the Agency of the required in-servicing prior to any further scheduling of Agency staff. In addition, the DON was tracking to ensure no Agency staff worked prior to being trained. She stated no Agency staff had worked since the education was initiated.</p>	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 28 Continued interview with the DCO revealed the facility developed written Post-Tests to be administered to ensure staff retention of knowledge gained during the in-services. She stated staff were required to score 100% on the tests. Re-education was to be provided on-the-spot until the employee demonstrated 100% knowledge of the questions. Further interview revealed thirty (30) tests were to be administered weekly for the next six (6) weeks, and then monthly for six (6) months. The DCO stated the intent was to reach every staff member more than once to ensure continued knowledge retention. Review of completed post-tests revealed ten (10) tests were administered on 02/04/15, seventeen (17) on 02/05/15 and fourteen (14) on 02/06/15. Continued review revealed all tests were completed with 100% accuracy. Further review revealed two (2) newly hired staff that began the orientation process during the course of the State Agency survey completed the written post-tests with a score of 100%. Review of the "Pre-Hire Paperwork - Document Guide" revealed scabies education was included in the list of required documents. Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:56 PM, SRNA #23 on 01/29/15 at 2:04 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #8 on 01/29/15 at 4:37 PM, RN #2 on 01/29/15 at 4:38 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 29 #11 on 01/30/15 at 3:35 PM, SRNA #24 on 01/30/15 at 3:55 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, Wound Care Nurse on 02/04/15 at 3:20 PM, RN #1 on 02/05/15 at 4:30 PM, LPN #6 on 02/05/15 at 4:55 PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Worker #26 on 02/06/15 at 2:00 PM, Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, and Laundry Worker #25 on 02/06/15 at 6:20 PM, revealed all had received training related to scabies. All interviewed stated they had received the "Scabies Fact Sheet" and "Scabies Guidelines" during the in-services. All were able to answer specific questions related to their role in managing an outbreak of scabies and their specific duties related to the facility's current action plan. In addition, specific questions from the written post-test were included in the interviews, with all those interviewed able to respond correctly. 19. Review of in-service records, dated 01/30/15, revealed the DCO educated the DON related to infection control, with emphasis on maintaining surveillance logs, tracking the data and trending for any possible outbreak. Included in the training was a review of two (2) new monitoring tools, the "Scabies/Rash Tracking Log" and the "Skin Inspection Log". In addition, the facility's policy titled "Surveillance for Infections", dated December 2012, was reviewed. Interview with the DON, on 02/06/15 at 1:50 PM, revealed she was responsible for infection control surveillance in the facility. She stated the education, including the new tracking logs, gave her tools going forward to correctly identify potential concerns. She explained every resident in the building was currently being tracked	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 30</p> <p>because all had received treatment for scabies; however, in the future all new rashes or other skin issues could be tracked by using the forms. Continued interview revealed she also utilized a facility "map" and color-coded entries to identify any clusters of concern.</p> <p>Interview with the DCO, on 02/05/15 at 2:45 PM, revealed the intent of the education was to ensure a series of rashes among multiple residents would not be missed as a potential outbreak in the future. She stated once the current issues were resolved, rashes would continue to be tracked in order to identify or exclude an infection-control concern.</p> <p>Review of the "Scabies/Rash Tracking Log" and the "Skin Inspection Log" revealed rashes were tracked by resident name and room number, date rash identified, treatment initiation and completion date and resolution of the rash. Review of the "Skin Inspection Log" revealed each resident was tracked, based on skin assessments performed by the licensed nurses, for new areas, Physician notifications, orders and resolution. In addition, the log included areas for review by the DON to ensure staff were compliant in following through on identified skin concerns.</p> <p>20. Review of in-service records revealed the DCO provided education to the MDS coordinator on 01/30/15 related to the Care Plan. Emphasis was on ensuring the Care Plan addressed specific problems, goals, interventions and ongoing monitoring.</p> <p>Interview with the MDS Coordinator, on 02/05/15 at 6:45 PM, revealed she had received training from the DCO related to required components of</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 31</p> <p>the Care Plan, including stating of the problem, goals and specific interventions, including interventions related to continued monitoring. She stated she developed a Care Plan for every resident who received treatment, first all residents on the B wing, then every resident on the A wing, and ultimately every resident in the facility. She further stated the Care Plans would continue to be revised as needed to reflect any changes in status or treatment for each resident. Continued interview revealed she began the Care Plan revisions on 01/26/15 and continued with each new resident as treatment was ordered. The MDS Coordinator stated she did not need to make additional changes after receiving training from the DCO, but was able to verify she was including all necessary components on the Care Plans after the training.</p> <p>21. Review of documented skin assessments revealed all residents were assessed twice weekly for any skin issues, including new or ongoing rashes, beginning 01/31/15. The findings of these assessments were entered on the "Skin Inspection Log" and reviewed daily by the DON for appropriate response to the findings, e.g. notification of the Physician and initiation of treatments as ordered.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed she reviewed the "Skin Inspection Logs" daily with the Administrator, to ensure ongoing compliance by the nursing staff related to documenting skin assessment findings and Physician notification when indicated with initiation of treatments as ordered. She stated any concerns identified upon review of the logs would result in immediate re-education of the staff responsible.</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 32 22. Review of the "QAPI Business Action Plan" revealed a QA meeting was held on 01/31/15 and attended by the Administrator, the DON, the Regional Vice President, the DCO and the Medical Director. Continued review revealed discussion regarding the Immediate Jeopardy (IJ), with an outline of each federal tag. The stated goal was to achieve compliance related to failures which contributed to the IJ. An outline of all actions already taken by the facility and those which were ongoing, and who was responsible for coordinating the activities, was included in the outline and was reviewed by meeting attendees. 23. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed either she or the Regional Vice President had been present in the building daily since 01/31/15 after the facility was notified of the IJ on 01/30/15. Review of training records, QA meetings, and documented interviews with State Survey Agency personnel provided evidence of her presence in the facility. She stated her primary role had been one of corporate oversight, and she had been closely involved in developing and ensuring implementation of the facility's action plan on a daily basis. The DCO further stated she had maintained collaboration with the corporate office via the Regional Vice President. 24. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed the facility's "Scabies Prevention and Control Plan" was based on implementation of the "Scabies Guidelines". She stated the guidelines, along with the "Scabies Fact Sheet" had been a foundation for training of staff. Continued interview revealed the new "Scabies/Rash Tracking Log" would be important for tracking rashes in the future, and met the	F 157			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 33</p> <p>intent of maintaining a high index of suspicion for scabies as a possible cause of an undiagnosed skin rash. Continued interview revealed as treatment had been initiated for all residents in the building, everyone was being tracked for effectiveness of the treatment. She further stated any resident who failed the current treatment program would be referred to the Dermatologist for follow-up.</p> <p>Review of the "Scabies Guidelines" revealed it was comprehensive approach to the prevention, identification and treatment of scabies. Continued review revealed specific guidelines related to cleaning and disinfecting, and laundering, to prevent re-infestation or spread to other individuals.</p> <p>25. Review of Departmental Notes for 02/03/15 revealed the Responsible Party for each resident on the A wing was notified by telephone of scabies present in the building, and the facility's plan for treatment and contact isolation precautions. For those residents who were self-responsible, notification to the resident was made by Social Services.</p> <p>26. Review of the Physician orders dated 02/04/15 revealed all remaining residents on the A wing were to be treated for scabies, meaning that every resident in the facility had orders for treatment. Continued review revealed medication orders, and orders for contact isolation, were consistent with those for all other residents.</p> <p>Review of the MARs for those remaining A wing residents revealed treatment was initiated according to the Physician's orders.</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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 157	<p>Continued From page 34</p> <p>Observations, on 02/06/15 at 1:30 PM, 3:00 PM and 5:00 PM, revealed residents on the A wing were receiving baths or showers to remove the first application of Efimite cream. Continued observations revealed personal clothing, linens and privacy curtains were laundered, washable surfaces in the residents' rooms were disinfected, and non-washable items were wrapped in plastic and stored in the outbuilding, according to the facility's "Guidelines for Scabies".</p> <p>27. Clinical record review revealed Residents #1 and #10, with confirmed diagnoses of scabies on 01/26/15, had follow-up appointments scheduled with the Dermatologist for 02/06/15.</p> <p>28. Interviews and record reviews validated QA monitoring as follows:</p> <p>Review of the "Scabies/Rash Tracking Log" revealed all residents in the building were included, as all had received treatment for scabies. Continued review revealed the DON or the Administrator signed off on each resident entry daily, beginning on 02/02/15 and ongoing.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed each resident would stay on the log for at least seven weeks, to ensure the treatment was effective and all symptoms of itching and rashes were resolved. She stated the extra weeks would allow identification of re-infestation, as symptoms take two (2) to six (6) weeks to manifest.</p> <p>Review of the "Skin Inspection Log" revealed each resident was added to the log when their bi-weekly skin assessment was completed, or any time a new skin concern was identified and</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	<p>Continued From page 35</p> <p>an assessment was performed. Continued review revealed the DON or the Administrator signed off on the log each day, beginning on 02/02/15 and ongoing.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed she and the Administrator reviewed the "Skin Inspection Log" daily to ensure the nursing staff was compliant in identifying, documenting and making appropriate notifications of new skin concerns. She stated the RN Supervisor would be responsible for reviewing the log on the weekends, and the DON and Administrator would review the weekend logs on Mondays. Continued interview revealed any concerns identified during the daily reviews would result in immediate re-education of the responsible staff.</p> <p>Review of the "Care Plan Audit Log" revealed the first weekly audit of Care Plans for residents being treated for scabies was completed and signed by the DON on 02/04/15. Currently, all resident Care Plans were reviewed as all residents received treatment.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed she would be reviewing the Care Plans weekly for a total of eight (8) weeks to ensure new revisions were made as indicated by the resident's response to treatment. She stated any identified concerns with her review of all logs would be addressed immediately by re-education. Continued interview revealed results from all audits would be presented at each monthly QA meeting for discussion.</p> <p>Interview with the Administrator, on 02/06/15 at 2:45 PM, revealed he had remained closely involved with the development and</p>	F 157		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 157	Continued From page 36 implementation of the facility's action plan related to the IJ. He stated, along with the DON and the DCO, he had ensured all staff was educated related to the facility's "Scabies Prevention and Control Plan". Continued interview revealed his role included reviewing audits daily, ensuring PPE and other needed supplies were readily available, speaking with families, and making observations to ensure the facility's plan was followed according to Physician orders and the written guidelines. The Administrator further stated all audits results would be reviewed at each QA meeting, with the next scheduled meeting being 02/09/15, and regular monthly meetings occurring on the first Monday of the month.	F 157			
F 280 SS=K	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents identified to have been found affected by the deficient practice citing include Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14 and #16 in addition unsampled residents A,B,C,D,E,F,G and H. On 1/27/15, the MDS Coordinator revised the plan of care for all residents receiving treatments that included each of the residents identified in the deficient practice citing, along with unsampled residents, to thoroughly reflect current		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, the facility failed to have an effective system to ensure care plans were reviewed and revised to reflect the resident's current condition for fourteen (14) of sixteen (16) sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14, and #16).</p> <p>Interview and record review revealed a treatment for Scabies (a very contagious microscopic human itch mite which causes intense itching and skin irritation) was prescribed and initiated from 07/21/14 through 07/23/14, for four (4) residents (Residents #5, #6, #7 and #9). On 07/27/14, Residents #1, #2, #3, #4, #8, #10, #11, #12 and #14 as well as eight (8) unsampled residents (Unsampled Residents A, B, C, D, E, F G and H) were also treated for Scabies. However, on 07/27/14, there was no documented evidence Contact Isolation Precautions were added as a care plan intervention, and no evidence the care plan was revised to include implementation of monitoring for the effectiveness of the treatment or monitoring the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines. On 08/20/14, Resident #7 required re-treatment with scabies topical medications, and on 08/21/14 and 01/02/15, Resident #6 required re-treatment with scabies topical medications.</p> <p>The facility's failure to have an effective system in place to ensure the care plans were reviewed and</p>	F 280	<p>problem, treatment and interventions including isolation precautions, monitoring for side effects and for as needed medication or intervention to address itching or other side effects, as well as effectiveness of interventions.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. All residents that had presented with rash were reviewed for care plan accuracy and revised if indicated.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? On 1/30/15, the Director of Clinical Operations educated the MDS Coordinator on ensuring care plans for scabies/rash include/address specific problem, goal, interventions and on-going monitoring for potential need in change of treatment. The nursing 24 hour report and prior day physician orders are reviewed each weekday morning in Clinical Start Up meeting</p>	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 38</p> <p>revised to reflect each resident's current condition has caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 01/30/15 and found to exist on 07/27/14, and the facility was notified on 01/30/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 02/05/15, with the facility alleging removal of the Immediate Jeopardy on 02/05/15. The State Survey Agency verified removal of the Immediate Jeopardy on 02/05/15 as alleged, prior to exit on 02/06/15, with remaining non-compliance at Scope and Severity of an "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance program monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Comprehensive Plan of Care", effective 08/01/12, revealed the purpose was to provide an individualized Plan of Care for each resident. Continued review revealed the Comprehensive Care Plan should describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, with measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the Comprehensive Assessment. Per the facility's policy, the Comprehensive Care Plan was to be updated to reflect the resident's current condition at least every ninety (90) days, or whenever significant changes occurred. Further review revealed progress or the lack of progress toward the goal</p>	F 280	<p>that is attended by the Administrator, Director of Nursing, MDS, Social Services, Business Office Manager, Staff Development Coordinator and Dietary Manager to ensure that the follow up measures have been implemented to include appropriate care plan updates. This meeting is led by the Director of Nursing Services or member of the nursing leadership team. In the absence of the MDS Coordinator, one of the remaining Clinical Start-Up team members, either the Director of Nursing or Staff Development Coordinator, would ensure that the plan of care had been updated accordingly. The center implemented the "Scabies/Rash Tracking Log for residents with rashes and new admissions that is to be reviewed daily for 6 weeks by the Administrator, DNS or the RN Supervisor. Also, the 'Skin Inspection Log" will be reviewed by the Administrator, DNS or the RN Supervisor daily for 4 weeks, to identify an issues and interventions will be implemented and the Care Plans of residents being treated will be reviewed by the Administrator, DNS or RN</p>	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 39
was to be documented each time the Care Plan was reviewed, noting the probable reason for success or failure.

Review of the facility's policy titled "Care System Guidelines - Skin Care", undated, revealed the Director of Nursing Services (DON) or designee was responsible for implementing and monitoring the skin integrity program. Further review revealed a key element was for any skin risk identified to have corresponding interventions in the plan of care. Per the policy, the plan of care would address problems, goals, and interventions directed towards identified skin integrity concerns.

Review of the facility's policy titled "Isolation - Categories of Transmission-Based Precautions", revised August 2012, revealed the facility would ensure each resident's care plan and care specialist communications system indicated the type of precautions implemented for the resident.

Interview with Registered Nurse (RN) #1, on 01/30/15 at 4:00 PM, revealed the Minimum Data Set nurse was responsible for updating the care plans. Further interview revealed the care plan should consist of the problem area to be addressed, the goal and date of the goal, with the interventions listed. RN #1 stated the care plan for a resident receiving treatment for scabies should include the treatment received, if the resident was placed in isolation, and monitoring of the rash. Further interview revealed she did not know if the residents' care plans related to scabies included any of these interventions.

1. Record review revealed Resident #1 was admitted by the facility on 09/12/13, and re-admitted 07/03/14, with diagnoses which

F 280 Supervisor weekly for 8 weeks to review interventions.

How will the facility monitor performance to ensure solutions are sustained? The center Administrator, DNS or RN Supervisor will review the "Scabies/Rash Tracking Log" and the "Skin Inspection Log" daily for 6 weeks including new admissions, then weekly for 4 weeks, and monthly as part of the on-going QA process. The "Scabies/Rash Tracking Log" is completed by the Director of Nursing on weekdays, with the RN Supervisor being responsible for completion on weekends. The Administrator, DNS or RN Supervisor will review the "Skin Inspection Log" daily for 6 weeks; then weekly for 4 weeks, then followed monthly as part of the QA process. The "Skin Inspection Log" is completed by the Director of Nursing on weekdays, with the RN Supervisor being responsible for completion on weekends. The care plans of those residents affected will be reviewed weekly for 8 weeks and then also during the monthly QA process. These reviews shall capture

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 40 included Sepsis, Urinary Tract Infection, Diabetes, Iron Deficiency Anemia, Venous Insufficiency, Chronic Kidney Disease and Hypertension. Review of the Quarterly MDS Assessment, dated 12/01/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Review of the Comprehensive Care Plan for Resident #1 revealed the facility had care planned the resident to be at risk for an impairment in skin integrity related to chronic bilateral lower extremity cellulitis. Further review of the Care Plan revealed the facility identified Resident #1 to have a rash between his/her toes on 04/11/14, at which time treatments were implemented. Continued review revealed the Care Plan was revised to include Permethrin Cream (treatment for Scabies) to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as an intervention, and no evidence the Care Plan was revised to include implementation of monitoring for the effectiveness of the treatment or monitoring of the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines. 2. Record review revealed Resident #2 was admitted by the facility on 05/25/14 with diagnoses which included Pneumonia, Chronic Airway Obstruction, Congestive Heart Failure and Anxiety. Review of the Quarterly MDS Assessment, dated 11/16/14, revealed the facility assessed Resident #2 to have a BIMS score of eleven (11) out of fifteen (15), which indicated the resident exhibited moderate cognitive	F 280	any identified issues with care plan updates and tracking of rash issues that will be followed monthly in the Quality Assurance Process Improvement (QAPI) meeting for additional interventions required. The monthly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Staff Development Coordinator, Medical Records Director, Activity Director and Social Services Director, Housekeeping/Laundry Supervisor, Maintenance Supervisor, Business Office Manager and Dietary Manager. The Medical Director and consulting pharmacist attend the QAPI meeting quarterly, at a minimum; however, monthly QAPI meetings have already been scheduled with the Medical Director to ensure attendance at each meeting. The members of the QAPI Committee will make recommendations regarding further monitoring and continued compliance.	3/10/15	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 41 impairment.

Review of the Comprehensive Care Plan revealed the facility care planned Resident #2 for a potential impairment in skin integrity related to a self-care deficit. Further review of the Care Plan revealed the facility identified Resident #2 to have a rash and itching on 06/08/14 with an order for oral Benadryl for one (1) day. Further review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14, however, there was no documented evidence Contact Isolation Precautions were added as a care plan intervention, and no evidence the Care Plan was revised to include monitoring of the rash to ensure effectiveness of the treatment and eradication of the infestation, per the facility's policies and guidelines.

3. Record review revealed Resident #3 was admitted by the facility on 03/22/13 with diagnoses which included Chronic Airway Obstruction, Diabetes, Chronic Pain Syndrome, Drug Dependence, Hypothyroidism, Hypertension, Depressive Disorder and Anxiety. Review of the Significant Change MDS Assessment, dated 01/19/15, revealed the facility assessed Resident #3 to have a BIMS score of twelve (12), indicating the resident was moderately cognitively impaired.

Review of the Comprehensive Care Plan revealed the facility had care planned Resident #3 for the risk of impaired skin integrity related to recurrent bilateral lower left extremity cellulitis. Further review of the Care Plan revealed the facility identified Resident #3 to have a rash or itching on 06/30/14, with Hydrocortisone cream and Benadryl ordered for the symptoms.

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 42</p> <p>Continued review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions was added as a care plan intervention, and no evidence the Care Plan was revised to include the implementation of monitoring for the effectiveness of the treatment, or monitoring of the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines.</p> <p>4. Record review revealed Resident #4 was admitted by the facility on 09/13/12 with diagnoses which included Chronic Airway Obstruction, Encephalopathy, Diabetes, Hypothyroidism, Anxiety, Depressive Disorder and Dementia with Behavior Disturbances. Review of the Annual MDS Assessment, dated 02/14/15, revealed the facility assessed Resident #4 to have a BIMS score of seven (7), which indicated the resident was severely cognitively impaired.</p> <p>Review of the Comprehensive Care Plan revealed the facility assessed Resident #4 to be at risk for skin integrity impairment related to a history of chronic Stage Two (2) diabetic ulcers, and related to the resident "picking" at self. Further review revealed the care plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence the Care Plan was revised to include Contact Isolation Precautions, or monitoring of the rash for treatment effectiveness and alleviation of symptoms, to ensure eradication of the scabies infestation per the facility's policies and guidelines.</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 43 5. Record review revealed, Resident #5 was admitted by the facility on 04/16/12 with diagnoses which included Hypothyroidism, Osteoarthritis, Muscle Weakness, Urine Retention, Tremor and Depression. Review of the Quarterly MDS Assessment, dated 12/02/14, revealed the facility assessed Resident #5 to have a BIMS score of eight (8), indicating moderate cognitive impairment. Review of the Comprehensive Care Plan revealed the facility assessed Resident #5 to be at risk for impaired skin integrity, related to frailty and weakness, and the need for assistance with all care. Further review of the Care Plan revealed the facility identified Resident #5 to have a rash on 06/11/14, when an oral steroid was initiated related to the rash. Further review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as an intervention, and no evidence the Care Plan was revised to include implementation of monitoring for the effectiveness of the treatment, or monitoring of the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines. 6. Record review revealed Resident #6 was admitted by the facility on 12/17/13 with diagnoses which included General Osteoarthritis, Chronic Airway Obstruction, Hypertension, and Failure to Thrive-Adult. Review of the Annual MDS Assessment, dated 01/11/15, revealed the facility assessed Resident #6 to have a BIMS score of six (6), which indicated severe cognitive impairment.	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 44</p> <p>Review of the Comprehensive Care Plan revealed the facility assessed Resident #6 to be at risk for impaired skin integrity related to low body weight and end-stage Chronic Obstructive Pulmonary Disease. Further review of the Care Plan revealed on 06/09/14 the facility identified Resident #6 to have a rash on his/her chest and axillary area, with Hydrocortisone Cream ordered. Further review revealed the care plan was revised to include Permethrin Cream to be applied on 07/21/14, 08/21/14, 09/10/14 and 12/15/14; however, there was no documented evidence the Care Plan was revised at any time to include Contact Isolation Precautions interventions, and no evidence the Care Plan was ever revised to include the implementation of monitoring for the effectiveness of the treatment, or monitoring the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines.</p> <p>7. Record review revealed Resident #7 was admitted by the facility on 05/17/14 with diagnoses which included Urinary Tract Infection, Gastrointestinal Hemorrhage, Esophageal Reflux, Alzheimer's Disease and Dementia. Review of the Quarterly MDS Assessment, dated 12/15/14, revealed the facility assessed Resident #7 to have a BIMS of eight (8), indicating moderate cognitive impairment.</p> <p>Review of the Comprehensive Care Plan revealed the facility assessed Resident #7 to be at risk for skin integrity impairment related to a self-care deficit and the need for extensive staff assist. Further review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation</p>	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280

Continued From page 45

Precautions were added as an intervention, and no evidence the Care Plan was revised to include monitoring for the effectiveness of the treatment or monitoring of the rash to ensure the scabies were eradicated, per the facility's policies and guidelines.

8. Record review revealed Resident #8 was admitted by the facility on 01/28/14 with diagnoses which included Depressive Disorder, Anxiety, Irritable Bowel Syndrome, and Lupus Erythematosus. Review of the Quarterly MDS Assessment, dated 01/14/15, revealed the facility assessed Resident #8 to have a BIMS of six (6), indicating the resident was severely cognitively impaired.

Review of the Comprehensive Care plan revealed the facility care planned Resident #8 for a potential of impaired skin integrity related to frequent bowel and bladder incontinence, and a self-care deficit. Further review of the Care Plan revealed the facility identified Resident #8 to have a rash or itching on 06/30/14, with Hydrocortisone cream and oral Benadryl ordered. Continued review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as an intervention, and no evidence the Care Plan was revised to include the implementation of monitoring for the effectiveness of the treatment or monitoring of the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines.

9. Record review revealed Resident #9 was admitted by the facility on 01/02/14 with

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 46 diagnoses which included Pneumonia, Acute Kidney Failure, Muscle Weakness, and Cognitive Communication Deficit. Review of the Annual MDS Assessment, dated 12/30/14, revealed the facility assessed Resident #9 to have a BIMS score of three (3), indicating severe cognitive impairment. Review of the Comprehensive Care plan revealed the facility care planned Resident #9 for potential skin integrity impairment related to frequent bladder incontinence. Further review of the Care Plan revealed, on 06/09/14, the facility identified Resident #9 to have a rash on his/her back with Hydrocortisone cream ordered. Continued review revealed the care plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as an intervention, and no evidence the Care Plan was revised to include implementation of monitoring for the effectiveness of the treatment or monitoring of the appearance of the rash to ensure the scabies were eradicated, per the facility's policies and guidelines. Additional review revealed Resident #9 was admitted to an acute care hospital on 01/03/15, where he/she was identified to have scabies and the resident was administered treatment at the hospital. 10. Record review revealed Resident #10 was admitted by the facility on 08/05/10 with diagnoses which included Peripheral Vascular Disease, Depressive Disorder, Esophageal Reflux, Dysphagia, and Joint Contractures. Review of the Quarterly MDS Assessment, dated 11/13/14, revealed the facility assessed Resident #10 to have a BIMS score of three (3), which indicated severe cognitive impairment.	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280

Continued From page 47

Review of Resident #10's Comprehensive Care Plan revealed the resident was assessed by the facility to be at risk for skin integrity impairment related to a self-care deficit, bowel incontinence and the presence of pressure ulcers. Further review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as a care plan intervention, and no evidence the care plan was revised to include monitoring for the effectiveness of the treatment or monitoring of the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines.

11. Record review revealed Resident #11 was admitted by the facility on 09/03/85 with diagnoses which included Hypertension, Convulsions, Esophageal Reflux and Intellectual Disability. Review of the Quarterly MDS Assessment, dated 01/16/15, revealed the facility assessed Resident #10 to have a BIMS score of twelve (12), which indicated moderate cognitive impairment.

Review of the Comprehensive Care Plan revealed the facility assessed Resident #11 to be at risk for impaired skin integrity related to impaired mobility, non-ambulatory status and decreased range of motion. Further review of the care plan revealed on 06/28/14, the facility identified Resident #11 to have redness on his/her sacrum with "Magic Butt" cream ordered. Continued review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation

F 280

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

PRINTED 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 48</p> <p>Precautions were added as a care plan intervention, and no evidence the Care Plan was revised to include the implementation of monitoring the appearance of the rash and the effectiveness treatment to ensure the scabies were eradicated, per the facility's policies and procedures.</p> <p>12. Record review revealed Resident #12 was admitted by the facility on 03/12/14 with diagnoses which included Bronchitis, Muscle Weakness, Symbolic Dysfunction, Congestive Heart Failure and Dementia. Review of the Quarterly MDS Assessment, dated 11/20/14, revealed the facility assessed Resident #12 to have a BIMS of three (3), which indicated severe cognitive impairment.</p> <p>Review of the Comprehensive Care Plan revealed the facility assessed Resident #12 to be at risk for skin integrity impairment related to a requirement for staff assistance for activities of daily living. Further review revealed the facility identified Resident #12 to have a rash to his/her axilla and perineal area on 06/12/14, and an oral steroid was ordered. Continued review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence the Care Plan was revised to include Contact Isolation Precautions or interventions related to monitoring the resident's rash and effectiveness of the treatment, to ensure the scabies were eradicated, per the facility's policies and procedures.</p> <p>13. Record review revealed Resident #14 was admitted by the facility on 06/05/14, and re-admitted on 08/11/14, with diagnoses which included Urinary Tract Infection, Chronic Airway</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 49</p> <p>Obstruction, Muscle Weakness, and Alzheimer's Disease. Review of the Quarterly MDS Assessment, dated 11/22/14, revealed the facility assessed Resident #14 to have a BIMS score of six (6), indicating severe cognitive impairment.</p> <p>Review of Resident #14's Comprehensive Care Plan revealed the facility assessed Resident #14 to be at risk for impaired skin integrity related to a self-care deficit and incontinence of bowel and bladder. Continued review revealed the Care Plan was revised to include Permethrin Cream to be applied on 07/27/14; however, there was no documented evidence Contact Isolation Precautions were added as an intervention, and no evidence the Care Plan was revised to include monitoring for the effectiveness of the treatment or the appearance of the rash to ensure eradication of the infestation, per the facility's policies and guidelines.</p> <p>14. During the Partial Extended Survey, Resident #16 was identified by the State Survey Agency to have a rash and itching.</p> <p>Interview with Resident #16, on 02/04/15 at 8:05 AM, revealed the resident reported itching on his/her back for about two (2) weeks. Continued interview revealed the resident did report the itching to staff, but was not aware of any new treatment orders. The resident stated the nurse put some lotion on the itch but it only helped for a short time.</p> <p>Observation of a skin assessment conducted by LPN #2, on 02/04/15 at 9:58 AM, revealed Resident #16 had red linear abrasions on the left lower back. In addition, the resident exhibited a raised red rash in clusters on the upper back,</p>	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 50</p> <p>neck and both shoulders. Continued observation revealed a scabbed area behind the right ear. At the time of the skin assessment, Resident #16 stated he/she had scabies many years ago, and this felt exactly the same.</p> <p>Clinical record review revealed Resident #16 was admitted by the facility on 01/16/15 for rehabilitation after a fall at home, and was receiving occupational therapy, speech therapy and physical therapy five (5) times per week. Review of the Brief Interview for Mental Status (BIMS), dated 01/23/15, revealed the facility assessed Resident #16 to have a score of fifteen (15) which indicated the resident was cognitively intact and interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #16, dated 01/16/15, revealed the resident was assessed by the facility to be at risk for impaired skin integrity. However, the Care Plan was not revised to address the specific problem of the resident's itching and scratching, and it did not include a treatment goal or interventions for managing the symptoms.</p> <p>Interview with the MDS Coordinator, on 01/30/15 at 4:20 PM, revealed she was responsible for updating the Comprehensive Care Plan. Further interview revealed the care plans should list the problem area, goals to be achieved with a date to achieve the goal and interventions that would be used to address the problem and achieve the goal. Continued interview revealed the facility's process was to update the care plan daily based on new physician orders, and at least quarterly in conjunction with the MDS assessments. She stated for residents with confirmed or suspected scabies and ordered treatment, the care plans</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 51</p> <p>should include contact isolation, decontamination of resident rooms and community areas, and monitoring for effectiveness of treatment as interventions.</p> <p>Interview with the Director of Nursing (DON), on 01/30/15 at 5:07 PM, revealed the MDS Coordinator was responsible for updating the care plans. She stated care plan updates were completed daily based on physician orders. Continued interview revealed if a rash were identified, interventions should include monitoring of the rash for effectiveness of treatments ordered. In addition, if a resident were treated for scabies, the Care Plan should reflect interventions consistent with the facility's policies and procedures for managing a scabies infestation, such as Contact Isolation Precautions. She further stated the Care Plan should include the stated problem and treatment goals, as well as interventions to be implemented.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 02/05/15 which alleged removal of the IJ effective 02/05/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. On 01/26/15, the Medical Director and the Director of Nursing (DON) assessed ten (10) residents identified to have current treatment orders for a change in skin condition. 2. On 01/26/15, body audits were completed on all in-house residents by an RN and a LPN. Based on the skin assessments, the Medical Director gave verbal orders for STAT (immediate) dermatology appointments for three (3) of the residents. Appointments were made for the 	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 52</p> <p>same day. Two (2) of the three (3) residents (Residents #1 and #10) were confirmed to have scabies.</p> <p>3. On 01/26/15, the Medical Director was notified of the positive for results and orders were given to treat all thirty-one (31) residents on the B-wing for scabies. The orders included the following for all of the residents: contact precautions; Elimite cream to be applied beginning 01/27/15 and repeated in seven (7) days; and Stromectal tablets to be administered on day 1, 2, 8, 9, and 15 of the treatment process. The Responsible Party for all residents on the B wing was notified of the treatment orders by the Assistant DON (ADON) or the Activities Director.</p> <p>4. On 01/26/15, all B wing residents were placed on contact isolation per the facility's guidelines. The DON, Director of Clinical Operations (DCO), Administrator and the Housekeeping/Laundry supervisor placed signs on all resident doors and on entrance doors. Personal Protective Equipment (PPE) was distributed and each department was notified of the precautions in place.</p> <p>5. On 01/26/15, the DCO educated the DON and the Administrator related to scabies in long term care facilities, including prevention and control. The training included a review of the "Scabies Fact Sheet". The DON and the Administrator were educated by the DCO prior to proceeding to train all facility staff.</p> <p>6. On 01/26/15, the Administrator and the DON initiated education for all staff related to contact isolation procedures, including the appropriate application and removal of PPE. Staff was</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 53
required to complete the education prior to returning to work, with validation of effective learning through observation of staff adherence to isolation procedures and proper use of PPE.

7. On 01/26/15, an emergency Quality Assurance (QA) meeting was held and attended by the Administrator, DON, DCO, Housekeeping/Laundry Supervisor, Staff Development Coordinator (SDC) and the Medical director. The purpose of the meeting was to review the actions taken by the facility beginning 01/26/15.

8. On 01/27/15, all B wing residents were treated with Elimite cream, with application of the treatment by licensed nursing staff. The cream was left on for eight (8) to fourteen (14) hours before residents were bathed and dressed in clean clothes. The baths/showers were provided by the State Registered Nursing Assistants (SRNAs) and the LPN on duty, and the entire process was overseen by two (2) RNs.

9. On 01/27/15, all B wing residents received their first dose of Stromectal dose, as ordered by the Physician, administered by the LPN.

10. On 01/27/15, the Housekeeping/Laundry Supervisor provided training for all laundry and housekeeping staff related to cleaning of contaminated isolation rooms, per facility guidelines.

11. On 01/27/15, all linen items, including personal clothing, bed linens and privacy curtains were removed from each resident room on the B wing by laundry staff. The linens were washed separately from other residents in the facility.

F 280

1

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 54 using hot water and hot dryer cycles. The laundry machines were disinfected with bleach germicidal cleaner. All non-washable personal belongings were placed in sealed bags or wrapped in plastic wrap and quarantined outside the center, where they are to remain for fourteen (14) days per facility guidelines. The entire process was overseen by the Housekeeping/Laundry Supervisor. 12. On 01/27/15, furniture and equipment throughout the facility, including the common areas on both wings and the dining room, was disinfected with the bleach germicidal cleaner by housekeeping staff and monitored by the Housekeeping/Laundry Supervisor. 13. On 01/27/15, the Administrator contacted the local health Department by telephone and via e-mail to report the diagnosed scabies, rashes and treatment. 14. On 01/27/15, the Minimum Data Set (MDS) Coordinator revised the Care Plan for each resident receiving treatment. The revisions included the current problem related to scabies treatment, isolation precautions, treatment of itching, and monitoring for treatment side effects. 15. On 01/27/15, the option for treatment was provided to each employee of the facility. The DON began distributing Elimite cream on 01/27/15 along with verbal instructions. The DON is maintaining a log of staff who accepted treatment. On 02/03/15, the DON distributed a questionnaire to staff to determine if the treatment was effective and if staff continued to have symptoms and required additional treatment.	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 55

F 280

16. On 01/28/15, two (2) residents on the A wing began treatment for a rash identified on review of the skin audits by the DON. Treatment included contact isolation, application of Elimate cream with repeat application in one (1) week, and Stromectal tablets to be administered on day 1, 2, 8, 9 and 15. Resident rooms, clothing, personal items and equipment were cleaned per facility protocol.

17. On 01/28/15, the DON educated all licensed staff on accurately completing a skin assessment. The DON will oversee five (5) skin inspections weekly for six (6) weeks to ensure accuracy of assessment and competency of licensed staff. Any discrepancy will be immediately addressed and the nurse will be re-educated.

18. On 01/30/15, the Administrator and the DON initiated training on the "Scabies Fact Sheet" and the "Guidelines for Scabies" through handouts and discussion. The education for all staff to be completed by 02/04/15. Beginning 02/04/15, written post-tests were initiated for all departments to ensure staff retention of knowledge related to the training. Thirty (30) post-tests will be administered weekly for six (6) weeks and then monthly for six (6) months to ensure continued compliance. Any staff unable to complete the post-test with 100% accuracy will receive immediate re-education by the DON, Administrator or RN supervisor. Also beginning, 02/04/15, the "Scabies Fact Sheet" will be included in new employee orientation and annual infection control in-services. Any staff on leave and any agency staff will receive the education and complete the post-test prior to a return to work.

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 56

19. On 01/30/15, the DCO in-serviced the DON on infection control surveillance logs, tracking and trending for scabies or other rashes, and the need for ongoing monitoring. The proper use of the "Scabies/Rash Tracking Log" and the "Skin Inspection Log" was included in the training.

20. On 01/30/15, the DCO educated the MDS Coordinator related to ensuring the Care Plans related to scabies/rashes included the specific problem, goal, and interventions for ongoing monitoring.

21. Evaluation and monitoring of each resident receiving treatment will included skin inspections for resolution of rashes, and observation for new skin eruptions in two (2) to six (6) weeks per Centers for Disease Control (CDC) guidelines. Skin inspections will be completed by licensed staff on all residents in the facility twice weekly beginning 01/31/15 for seven (7) weeks and weekly thereafter. The Physician will be notified of any findings and treatment will be initiated per Physician orders. Residents treated will be monitored for response to treatment and the presence of any treatment side effects.

22. On 01/31/15, a QA meeting was held with the Administrator, DON, Regional Vice President (RVP), DCO and the Medical Director to re-evaluate all measures implemented since 01/26/15, and to outline action items moving forward.

23. As of 01/31/15, daily corporate oversight will occur until removal of abatement of the Immediate Jeopardy, then weekly for at least seven (7) weeks to ensure continued compliance

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 57 of Administration.</p> <p>24. On 01/31/15, the facility established a "Scabies Prevention and Control Plan" which included the following: implementation of the "Scabies Guidelines" based on CDC guidelines; promotion of a high index of suspicion for scabies as a possible cause of undiagnosed skin rash; and referral to a Dermatologist after a failed initial course of treatment.</p> <p>25. On 02/03/15, the Responsible Party for each A wing resident was notified by phone by the ADON or the Activities Director of a scabies outbreak, with messages left for those parties who did not answer.</p> <p>26. On 02/04/15, the Medical Director gave orders to initiate treatment on all remaining residents on the A wing. Treatment orders were the same as for all other residents in the building, and included disinfection of resident rooms, clothing, personal items and equipment. In addition, common areas were cleaned according to facility guidelines.</p> <p>27. Residents #1 and #10, with confirmed scabies diagnoses, will have a follow-up appointment with the Dermatologist on 02/06/15. The DON or the RN will accompany the residents to the physician's office.</p> <p>28. The facility's QA process will monitor implemented interventions as follows:</p> <p>The Administrator, DON or RN Supervisor will review the "Scabies/Rash Tracking Log" daily for six (6) weeks, then weekly for four (4) weeks, then monthly in the Quality Assurance/Process</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280	<p>Continued From page 58 Improvement (QAPI) meeting.</p> <p>The Administrator, DON or RN Supervisor will review the "Skin Inspection Log" daily for six (6) weeks, then weekly for four (4) weeks, then monthly in the QAPI meeting.</p> <p>The Administrator, DON or RN Supervisor will review the Care Plans of residents being treated for scabies weekly for eight (8) weeks, then monthly in the QAPI meeting.</p> <p>The Administrator and/or the DON will ensure all staff has successfully completed the training and post-test related to the facility's "Scabies Prevention and Control Plan".</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the Physician Extended Care Notes, dated 01/26/15 and signed by the Medical Director, revealed the ten (10) residents with treatment orders for a change in skin condition on that date were seen by the Physician for a complete physical examination and evaluation of their skin concerns. Continued review revealed each examination was comprehensive and included documentation by the Physician of each resident's skin and recommended treatment</p> <p>2. Review of the "Body Audit" forms, dated 01/26/15 and signed by the RN or the LPN, revealed sixty-five (65) residents in the facility received a head-to-toe skin assessment on that date. Continued review revealed each resident was assessed for eleven (11) specific skin conditions as follows: redness/discoloration/bruises; open areas; edema; rash; dry/flakey; excoriation; ecchymosis;</p>	F 280		
-------	--	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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)	
F 280	<p>Continued From page 59 -</p> <p>skin tears; abrasions; surgical wounds or incisions; and psoriasis. Findings were documented by type and location.</p> <p>Review of the Dermatologist's "Visit Notes", dated 01/26/15, revealed three (3) residents were seen in the office on that day. Continued review revealed two (2) of the three (3) residents (Residents #1 and #10), based on microscopic examination, were found to be positive for scabies and treatment orders were given. Additionally, the resident who did not have a confirmed diagnosis was treated prophylactically due to the resident's possible exposure to scabies.</p> <p>3. Review of the Physician Orders, dated 01/26/15, revealed the Medical Director gave orders for scabies treatment to be initiated on 01/27/15 for all residents on the B wing. Continued review revealed the orders were consistent with those given by the Dermatologist for the confirmed cases, with treatment to be administered as follows. apply Permethrin (Elimite) 5% cream to body from neck down, leave on 8-14 hours then wash off; repeat in one (1) week; after cream applied, administer Stromectal, 3 milligram (mg) tablets on day 1,2,8,9, and 15. In addition, Physician Orders included direction for contact isolation, dry skin lotion, and Benadryl PRN (as needed) for itching, for each resident.</p> <p>Review of Departmental Notes, dated 01/27/15, revealed the Responsible Party for each resident on the B wing was notified of the new orders by the Activities Director or the ADON.</p> <p>Interview with the ADON, on 02/04/15 at 2:02 PM,</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 60</p> <p>revealed she had made calls to the families of the B wing residents, informing them of new treatment orders and contact isolation procedures. She stated some families had questions and she answered as they arose.</p> <p>Interview with the POA for Unsampled Resident J, on 02/04/15 at 6:58 PM, revealed she was notified by the facility of treatment orders and isolation procedures for all residents on the B wing, including Resident J.</p> <p>4. Observation upon entering the facility, on 01/28/15 at 4:01 PM, revealed signs directing visitors to see the nurse prior to visiting with residents were posted on the front entrance doors and on the door of each resident room on the B wing. In addition, the signs on resident room doors indicated Contact Isolation was in effect. Continued observation revealed PPE, including gowns, masks, gloves and shoe covers, was stocked in bins in the hall outside resident rooms on the B wing. During survey activities throughout the day on 01/26/15, staff from all departments was observed to utilize the PPE prior to entering resident rooms. Also, staff was observed to dispose of PPE appropriately, in biohazard containers inside resident rooms, upon exit from the room.</p> <p>5. Review of training record signatures revealed the DCO provided training to the Administrator and the DON on 01/26/15. The in-service was titled "Scabies in Long Term Care" and utilized the "Scabies Fact Sheet", for education related to the prevention and control of scabies in the long term care setting. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed she educated the Administrator and DON to ensure they were</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 61
knowledgeable about managing a scabies outbreak, prior to their training of the rest of the staff, in order for all education to be consistent and according to facility guidelines.

Interview with the DON on 02/05/15 at 12:50 PM, and the Administrator on 02/06/15 at 2:45 PM, revealed both received training from the corporate DCO related to scabies infestation. Continued interview revealed the training by the DCO occurred prior to the Administrator and the DON educating the staff.

6. Review of training records revealed, on 01/26/15, the Administrator and the DON initiated education for all staff related to Isolation Precautions, with emphasis on contact precautions. Review of training materials revealed the education included the proper use of PPE. Further review of in-service sign-in sheets revealed eighty (80) of eighty (80) staff had received the mandatory training on or before 01/30/15.

Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:58 PM, SRNA #23 on 01/29/15 at 2:04 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #8 on 01/29/15 at 4:37 PM, RN #2 on 01/29/15 at 4:38 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA #11 on 01/30/15 at 3:35 PM, SRNA #24 on 01/30/15 at 3:55 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, Wound Care Nurse on 02/04/15 at 3:20 PM, RN #1 on 02/05/15 at 4:30 PM, LPN #6 on 02/05/15 at 4:55

F 280

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 62</p> <p>PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Worker #26 on 02/06/15 at 2:00 PM, Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, and Laundry Worker #25 on 02/06/15 at 6:20 PM, revealed all had received training related to isolation precautions. During the interviews, all were able to express the appropriate PPE required for contact isolation.</p> <p>Interview with the DON on 02/05/15 at 12:50 PM, and the DCO on 02/05/15 at 2:45 PM, revealed in addition to the eighty (80) "active" staff, three (3) staff members were currently on leave. Continued interview revealed the DON was responsible for scheduling and was tracking those staff members to ensure they were in-serviced prior to returning to work. Further interview revealed the facility had used Agency staff on occasion and notification was sent to the Agency of the required in-servicing prior to any further scheduling of Agency staff. In addition, the DON was tracking to ensure no Agency staff worked without receiving the education. She stated no Agency staff had worked at the facility since the in-services were initiated.</p> <p>Observations, on 01/28/15 at 11:30 AM and on 02/05/15 at 4:00 PM, revealed the Administrator, the DON and the Housekeeping Supervisor were on the resident units, observing staff and monitoring availability and proper use of PPE.</p> <p>7. Review of QA records revealed an "Emergency" meeting was held on 01/26/15 at 7:30 PM, and was attended by the Medical Director, the DCO, the Administrator, the DON, the Assistant DON and the Housekeeping Supervisor, as evidenced by their signatures. Meeting attendees reviewed the confirmed cases</p>	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280	<p>Continued From page 63</p> <p>of scabies, and recommendations from the Medical Director to treat all residents on the B wing, and to offer and encourage treatment to staff. Other items discussed included the initiation of Contact Precautions, body audits of all residents, cleaning and disinfection of resident rooms and common areas, and the prescribed treatment for the B wing residents.</p> <p>Interview with the Administrator, on 02/06/15 at 2:45 PM, revealed the Medical Director had been present and very involved in developing and implementing the facility's action plan to remove the Immediate Jeopardy. He stated although it was not in the QA minutes, he had a conversation with the Medical Director whose stated intent was to complete a re-assessment of every resident in the facility once the treatment was completed.</p> <p>8. Review of the Medication Administration Records for the B wing residents revealed all were treated with Elimite cream on 01/27/15. Continued review revealed the cream was applied by licensed nursing staff.</p> <p>Review of the facility's schedule for applying the cream and subsequent showering of each resident revealed a minimum of eight (8) hours elapsed between application and removal of the cream.</p> <p>Interviews with RN #2 on 01/29/15 at 4:35 PM, SRNA #18 on 01/31/15 at 2:47 PM, RN #1 on 02/05/15 at 4:30 PM, SRNA #4 on 02/05/15 at 4:38 PM, and SRNA #15 on 02/05/15 at 6:04 PM, revealed they had been involved in application of the Elimite cream and removal by bath or shower eight (8) to fourteen (14) hours later. The interviewees described the process whereby the</p>	F 280		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	<p>Continued From page 64</p> <p>cream was applied on one shift, and washed off on the next shift, following the same order of residents, according to the schedule. RN #1 and RN #2 reported they were responsible for applying the cream, and ensuring it was bathed off by the SRNAs, providing assistance if needed. The SRNAs stated they assisted the nurse with positioning during application of the cream, but their primary job was to bathe or shower the residents after at least eight (8) hours had passed.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed the RN or LPN on duty on the shift the cream was applied, and on the shift when removed, was responsible for overseeing the process. Continued interview revealed the DON took ultimate responsibility for ensuring each resident was treated appropriately, according to the Physician's orders. She stated she monitored the process by reviewing the MARs, interviewing staff and residents, and making observations of the application and removal of the cream.</p> <p>9. Review of the MARs for the B wing residents revealed all were administered Stromectal tablets, according to the Physician orders, on 01/27/15.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed her oversight of the treatment process included a review for timely administration of the Stromectal.</p> <p>10. Review of training records revealed the Housekeeping Supervisor provided education to eight (8) of eight (8) housekeeping and laundry staff on 01/27/15. Continued review revealed the education included the proper handling of trash</p>	F 280		

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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 280	<p>Continued From page 65</p> <p>and linens, cleaning and disinfecting of horizontal surfaces, walls, furniture and bathrooms, dust mopping and damp mopping, and proper disposal of trash and transport of linens to be laundered.</p> <p>Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 02/19/15 at 1:56 PM, Housekeeping Staff #12 on 01/29/15 at 2:07 PM, and Housekeeping Staff #11 on 01/29/15 at 2:19 PM, revealed all received training related to "deep cleaning" of contaminated isolation rooms. All interviewees were able to answer specific questions related to topics covered in the in-service, including the types of disinfectants to be used, as well as the process to be followed.</p> <p>Interview with the Housekeeping Supervisor, on 01/29/15 at 4:47 PM, revealed he had in-serviced his staff on 01/27/14 related to the procedure for cleaning and disinfecting the isolation rooms after an outbreak of scabies. He stated the process required a team effort and his role was to ensure his staff was educated, and to oversee the cleaning to ensure all steps were followed properly.</p> <p>11. Observation, on 01/28/15 at 11:30 PM revealed staff was in the process of decontaminating all resident linens, including personal clothing, bed linens and privacy curtains on the B wing. Linens had been transported to the laundry area on 01/27/15 for laundering using hot washer and dryer settings. Continued observation revealed resident room were cleaned and disinfected while the residents were out of the rooms for their baths or showers. All washable surfaces were disinfected with a bleach product, according to the facilities "Scabies</p>	F 280	

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(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)

F 280

Continued From page 66
Guidelines". No non-washable items, including cloth furniture, were observed anywhere in the facility, including resident rooms and common areas. The Housekeeping Supervisor was observed to be actively participating and overseeing the process. In addition, housekeeping staff were observed to be utilizing PPE during the cleaning.

Interview with Laundry Worker #25, on 02/05/15 at 5:30 PM, revealed she was responsible for laundering contaminated linens during her shift. She stated the linens arrived in the laundry area in red biohazard bags. She further stated the linens were removed from the bags and placed directly in the washer for laundering in hot water, followed by drying on the hot cycle for at least twelve (12) minutes. Continued interview revealed the process was followed for residents' personal clothing, bed linens, privacy curtains, "anything washable". Further interview revealed the washers and dryers were disinfected with a bleach disinfectant between uses.

12. Interview with the Housekeeping Supervisor, on 01/28/15 at 11:30 AM, revealed all furniture and equipment in common areas throughout the building was disinfected on 01/27/15. He stated the resident rooms, including washable furniture were being cleaned on 01/28/15 while residents were out of their rooms for bathing. He further explained all personal clothing, linens and privacy curtains had been removed prior to bathing to ensure the room was decontaminated prior to the residents returning. Continued interview revealed all cloth furniture and any items which could not be disinfected had been wrapped in plastic, removed from the building, and were stored in an outbuilding for the next fourteen (14) days, per

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 67 the facility's "Scabies Guidelines". 13. Review of e-mail correspondence, dated 01/27/15 at 9:40 AM, revealed the Administrator contacted the local Health Department and reported two (2) confirmed cases of scabies and the facility's decision to treat all residents on that unit. Continued review revealed the e-mail referenced an earlier voice mail left with the Health Department related to the same report. Review of Health Department documents revealed the facility received general information related to scabies and the "Scabies Fact Sheet" in response to their report. 14. Review of the Care Plans for fifteen (15) selected residents who were treated for scabies revealed a new care plan was developed for each resident on 01/26/15. Continued review revealed the Care Plans included the following: the problem of risk for scabies exposure; stated goals to identify and promptly treat any rashes, have no complications related to the rash; and have resolution of the rash; and interventions directed to addressing the problem and meeting the goals. Interventions included specific treatment orders, contact isolation, cleaning of resident rooms and belongings, monitoring of skin, monitoring for side effects of the medication, comfort measures including PRN (as needed) medications for itching and dry skin, and notification of the Physician as indicated by resident assessments and response to treatment. 15. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed all staff were offered the option to receive treatment for scabies. She stated the DON was tracking those employees who did	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 68

accept treatment. Continued interview with the DCO revealed questionnaires were distributed to all staff on 02/03/15 to determine if staff with symptoms had been treated and if treatment was effective.

Review of the log maintained by the DON revealed fifty-one (51) employees accepted treatment.

Review of the completed questionnaires revealed fifty-one (51) had been returned as of 02/03/15. Three (3) additional completed questionnaires were submitted by staff on 02/06/15. Continued review revealed the questionnaires addressed the presence of symptoms of a rash in the past sixty (60) days, whether treatment had been accepted and if it was effective, whether staff required repeat treatment or now desired to accept treatment for the first time, and whether staff needed additional education related to scabies.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed she had provided the Elimate cream to every staff member who requested it. She stated staff were educated on the symptoms of scabies and offered treatment during the training process. Continued interview revealed the questionnaires were designed to ensure the treatment was effective for those staff who accepted it, and to determine if there were other staff experiencing symptoms or desiring treatment.

Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:56 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM,

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280	<p>Continued From page 69</p> <p>SRNA #8 on 01/29/15 at 4:37 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, RN #1 on 01/30/15 at 3:20 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA #11 on 01/30/15 at 3:35 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, LPN #1 on 02/04/15 at 2:10 PM, SRNA #4 on 02/05/15 at 4:38 PM, LPN #6 on 02/05/14 at 5:00 PM, SRNA #15 on 02/05/15 at 6:04 PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Staff #26 on 02/06/15 at 2:00 PM and Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, revealed all had been offered treatment with Elimate cream for scabies, for symptoms of a rash/itching or prophylactically. All staff stated they were trained on scabies and how to use the cream if desired.</p> <p>16. Review of Physician orders for 01/28/15 revealed on the A wing, Resident #13 and his/her roommate who was not sampled, were to receive scabies treatment, including the Elimate cream to be applied on day 1 and repeated in one (1) week, and Stromectal tablets to be administered on day 1, 2, 8, 9 and 15. In addition, the residents were to be placed on contact isolation precautions.</p> <p>Review of the MAR for Resident #13 revealed treatment was initiated as ordered.</p> <p>Interviews with Housekeeping Staff #11 on 10/29/15 at 2:19 AM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #6 on 01/29/15 at 4:37 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, LPN #2 on 01/30/15 at 3:43 PM, and SRNA #10 on 01/30/15 at 3:55 PM revealed Resident #13 and his/her roommate were in contact isolation, their room had been cleaned and disinfected and personal clothing, bed linens and</p>	F 280		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 70 privacy curtains had been bagged for laundering. 17. Review of training records revealed the DON provided education to all licensed nursing staff related to completing a head-to-toe skin assessment on 01/28/15. Review of the training outline revealed topics covered included how and when skin assessments were to be completed, documentation of findings, and required notifications to family and Physician. Continued review revealed a question and answer session was provided and additional individual training was offered to all nursing staff. Interviews with RN #1 on 01/30/15 at 3:20 PM, LPN #2 on 01/30/15 at 3:43 PM, LPN #1 on 02/04/15 at 2:10 PM, and LPN #6 on 02/05/14 at 5:00 PM, revealed they had attended an inservice with the DON on 01/28/15 related to accurately performing a resident skin assessment. Continued interviews revealed the licensed staff were able to verbalize when skin assessments were to be completed, how to document their findings, and when and to whom notifications regarding the skin assessments were to be made. Interview with the DON, on 02/06/15 at 1:50 PM, revealed she would be monitoring five (5) skin assessments on the units weekly for six (6) weeks. She stated any identified problems observed would be addressed by immediate re-education. 18. Review of training records revealed the Administrator and the DON initiated training for all staff related to scabies. Educational handouts included the "Scabies Fact Sheet" and the "Guidelines for Scabies". Review of these	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 71

documents revealed they were comprehensive in describing symptoms, treatment and monitoring for response. In addition, information included the accepted process for handling laundry and cleaning and disinfection of rooms. Emphasis was on preventing spread of the infestation in an institutional setting.

Review of sign-in sheets revealed eighty (80) of eighty (80) staff received the education by 02/04/15. Three (3) staff were on leave and were required to complete the education prior to returning to work.

Interview with the DON, on 02/05/15 at 12:50 PM, revealed she was responsible for scheduling and was tracking the staff members on leave to ensure they were in-serviced prior to returning to work. Further interview revealed the facility had used Agency staff on occasion and notification was sent to the Agency of the required in-servicing prior to any further scheduling of Agency staff. In addition, the DON was tracking to ensure no Agency staff worked prior to being trained. She stated no Agency staff had worked since the education was initiated.

Continued interview with the DCO revealed the facility developed written Post-Tests to be administered to ensure staff retention of knowledge gained during the in-services. She stated staff were required to score 100% on the tests. Re-education was to be provided on-the-spot until the employee demonstrated 100% knowledge of the questions. Further interview revealed thirty (30) tests were to be administered weekly for the next six (6) weeks, and then monthly for six (6) months. The DCO stated the intent was to reach every staff member

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280	Continued From page 72 more than once to ensure continued knowledge retention. Review of completed post-tests revealed ten (10) tests were administered on 02/04/15, seventeen (17) on 02/05/15 and fourteen (14) on 02/06/15. Continued review revealed all tests were completed with 100% accuracy. Further review revealed two (2) newly hired staff that began the orientation process during the course of the State Agency survey completed the written post-tests with a score of 100%. Review of the "Pre-Hire Paperwork - Document Guide" revealed scabies education was included in the list of required documents. Interviews with Housekeeping Staff #13 on 01/29/15 at 1:34 PM, Housekeeping Staff #14 on 01/29/15 at 1:56 PM, SRNA #23 on 01/29/15 at 2:04 PM, Laundry Staff #12 on 01/29/15 at 2:07 PM, Housekeeping Staff #11 on 01/29/15 at 2:19 PM, SRNA #1 on 01/29/15 at 3:50 PM, SRNA #7 on 01/29/15 at 4:25 PM, SRNA #8 on 01/29/15 at 4:37 PM, RN #2 on 01/29/15 at 4:38 PM, Housekeeping Supervisor on 01/29/15 at 4:47 PM, SRNA #12 on 01/30/15 at 3:25 PM, SRNA #11 on 01/30/15 at 3:35 PM, SRNA #24 on 01/30/15 at 3:55 PM, LPN #2 on 01/30/15 at 3:43 PM, SRNA #9 on 01/31/15 at 4:00 PM, Wound Care Nurse on 02/04/15 at 3:20 PM, RN #1 on 02/05/15 at 4:30 PM, LPN #6 on 02/05/15 at 4:55 PM, Rehabilitation Staff #18 on 02/06/15 at 1:45 PM, Dietary Worker #26 on 02/06/15 at 2:00 PM, Rehabilitation Staff #17 on 02/06/15 at 3:05 PM, and Laundry Worker #25 on 02/06/15 at 6:20 PM, revealed all had received training related to scabies. All interviewed stated they had received the "Scabies Fact Sheet" and "Scabies	F 280		
-------	---	-------	--	--

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 73

Guidelines" during the in-services. All were able to answer specific questions related to their role in managing an outbreak of scabies and their specific duties related to the facility's current action plan. In addition, specific questions from the written post-test were included in the interviews, with all those interviewed able to respond correctly.

19. Review of in-service records, dated 01/30/15, revealed the DCO educated the DON related to infection control, with emphasis on maintaining surveillance logs, tracking the data and trending for any possible outbreak. Included in the training was a review of two (2) new monitoring tools, the "Scabies/Rash Tracking Log" and the "Skin Inspection Log". In addition, the facility's policy titled "Surveillance for Infections", dated December 2012, was reviewed.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed she was responsible for infection control surveillance in the facility. She stated the education, including the new tracking logs, gave her tools going forward to correctly identify potential concerns. She explained every resident in the building was currently being tracked because all had received treatment for scabies; however, in the future all new rashes or other skin issues could be tracked by using the forms. Continued interview revealed she also utilized a facility "map" and color-coded entries to identify any clusters of concern.

Interview with the DCO, on 02/05/15 at 2:45 PM, revealed the intent of the education was to ensure a series of rashes among multiple residents would not be missed as a potential outbreak in the future. She stated once the

F 280

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 280	Continued From page 74 current issues were resolved, rashes would continue to be tracked in order to identify or exclude an infection-control concern. Review of the "Scabies/Rash Tracking Log" and the "Skin Inspection Log" revealed rashes were tracked by resident name and room number, date rash identified, treatment initiation and completion date and resolution of the rash. Review of the "Skin Inspection Log" revealed each resident was tracked, based on skin assessments performed by the licensed nurses, for new areas, Physician notifications, orders and resolution. In addition, the log included areas for review by the DON to ensure staff were compliant in following through on identified skin concerns. 20. Review of in-service records revealed the DCO provided education to the MDS coordinator on 01/30/15 related to the Care Plan. Emphasis was on ensuring the Care Plan addressed specific problems, goals, interventions and ongoing monitoring. Interview with the MDS Coordinator, on 02/05/15 at 6:45 PM, revealed she had received training from the DCO related to required components of the Care Plan, including stating of the problem, goals and specific interventions, including interventions related to continued monitoring. She stated she developed a Care Plan for every resident who received treatment, first all residents on the B wing, then every resident on the A wing, and ultimately every resident in the facility. She further stated the Care Plans would continue to be revised as needed to reflect any changes in status or treatment for each resident. Continued interview revealed she began the Care Plan revisions on 01/26/15 and continued with each	F 280			

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

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 280 Continued From page 75
new resident as treatment was ordered. The MDS Coordinator stated she did not need to make additional changes after receiving training from the DCO, but was able to verify she was including all necessary components on the Care Plans after the training.

21. Review of documented skin assessments revealed all residents were assessed twice weekly for any skin issues, including new or ongoing rashes, beginning 01/31/15. The findings of these assessments were entered on the "Skin Inspection Log" and reviewed daily by the DON for appropriate response to the findings, e.g. notification of the Physician and initiation of treatments as ordered.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed she reviewed the "Skin Inspection Logs" daily with the Administrator, to ensure ongoing compliance by the nursing staff related to documenting skin assessment findings and Physician notification when indicated with initiation of treatments as ordered. She stated any concerns identified upon review of the logs would result in immediate re-education of the staff responsible.

22. Review of the "QAPI Business Action Plan" revealed a QA meeting was held on 01/31/15 and attended by the Administrator, the DON, the Regional Vice President, the DCO and the Medical Director. Continued review revealed discussion regarding the Immediate Jeopardy (IJ), with an outline of each federal tag. The stated goal was to achieve compliance related to failures which contributed to the IJ. An outline of all actions already taken by the facility and those which were ongoing, and who was responsible for

F 280