

Acceptable  
POC 5/31/13

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/10/2013
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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

AMENDED

A Recertification Survey was conducted 5/07/13 through 5/10/13. Deficiencies were cited with the highest Scope and Severity of a "D".

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  
SS=D

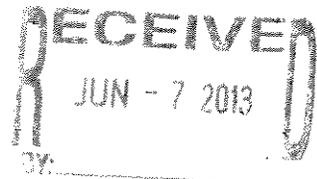
The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of the facility's policy, it was determined the facility failed to promote care for all resident's in a manner and in an environment that maintained or enhances each resident's dignity, for one (1) of twenty-five (25) sampled resident's (Resident #3). Observation revealed staff failed to completely pull the resident's privacy curtain and close the door to the shared bathroom when performing a skin assessment.

The findings include:  
Review of the facility's policy, titled "Resident Rights", not dated, revealed the resident had the right to personal privacy, which included accommodations, medical treatment, and personal care of the resident.

Observation, on 05/09/13 at 10:00 AM, revealed

F 000



F 241 F 241 Dignity and Respect

LPN #1 was reeducated by the DON on 5/9 on the need to assure each residents privacy during treatment and examination by closing doors and/or curtains completely.  
Resident # 3 (ADL score 15, BIMS score 7 on 4/26/2013 MDS) was interviewed by the administrator on 5/9/2013 to ascertain whether she suffered adverse effects as a result of the privacy violation as her R heel was being treated. Resident was unable to recall the event and seemed to suffer no ill effects.  
All direct caregivers were reeducated by the DON during the week of 5/27/2013 on the need to assure each residents privacy during examination, treatment and ADL care.  
Every resident of the facility could be affected by the practice cited.

Continued ...

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sanna Fudge</i>	TITLE Administrator	(X6) DATE 6/7/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 Continued From page 1

when Licensed Practical Nurse (LPN) #1 was performing a skin assessment for Resident #3, the privacy curtain was not completely closed and the door leading to the shared bathroom was left open. Further observation revealed the resident in the room on the other side of the shared bathroom, opened the bathroom door to wash his/her hands, and was able to see Resident #3 while the skin assessment was being performed.

Interview with LPN #1, on 05/09/13 at 11:15 AM, revealed she should have completely closed the privacy curtain while performing the skin assessment for Resident #3. She further stated she did not want to contaminate the curtain when she was going to wash her hands; however, the privacy curtain should have been completely closed to ensure the privacy of Resident #3.

Interview with the Director of Nursing (DON), on 05/10/13 at 4:40 PM, revealed when performing care for a resident, their privacy must be maintained. She stated the privacy curtain for Resident #3 should have been completely closed to ensure the resident's privacy and dignity were maintained.

Interview with the Administrator, on 05/10/13 at 4:45 PM, revealed when providing care for a resident, their privacy must be maintained at all times. She stated the privacy curtain was only open enough for the nurse to walk through so she could wash her hands without contaminating the curtain; however, by the curtain not being completely closed and the door to the shared bathroom being open, Resident #3's privacy was not maintained during the skin assessment.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO

F 241 F 241 Dignity and Respect (cont)

All employees are required to attend annual inservice education on residents rights including the right to privacy and dignity, talking respectfully to the residents, and assuring the residents are groomed as they desire and appropriately dressed. This inservice will be repeated to all staff on 6/10/2013 and 6/11/2013

Nurse Managers and supervisory staff will monitor daily during rounds, assuring that each residents' privacy and dignity is respected, talking respectfully to the residents, and assuring the residents are groomed as they desire and appropriately dressed. Staff members not providing privacy or treating the resident with dignity will be reeducated immediately by the nurse manager or supervisory staff member making the observation.

- Note - The undated policy referred to is found in the nursing policy and procedure manual. This manual is updated as needed, reviewed, and approved by the Medical Director, DON and LNHA on an annual basis.

Completion Date 05/31/2013

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F 280 Continued From page 2  
SS=D I 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.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twenty-five (25) sampled residents (Resident #4). Resident #4's Nutrition Care Plan was not revised to include current interventions and supplements. Resident #4's care plan was also not revised to include the resident's psychiatric diagnosis and risks associated with the use of psychotropic

F 280 F-280 Care Planning/Revision

- Resident # 4's nutritional care plan has been revised (attachment F-280 #1 /N192 #1)
- Resident # 4 also has a psychoactive drug care plan added addressing the use(s) of antidepressant and anti-anxiety medications (attachment F-280 #2/N192 #2)
- All residents prescribed a psychoactive drug have been reviewed to assure a psychoactive care plan is in place
- The unit managers have been and will continue to be responsible for the daily updates to the care plans as orders or the residents condition changes. A meeting was held by the clinical coordinator with the unit managers and MDS nurses on May 15<sup>th</sup> directing them to assure that psychoactive drug and all triggered areas are easily identifiable in the focus heading, all goals are measurable and interventions reasonable and thorough
- All care plans are being converted to electronic format. This process will be complete by the end of July. The MDS nurse will continue doing an extensive review/revision of each residents care plan as their OBRA assessments are done. The unit managers will be responsible for initiating new care plans as needed and the day-to-day updates of the care plans as orders/situations occur. On the psychoactive drug and nutritional care plans, the class of drug (i.e. antidepressant, appetite stimulant,

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F 280 Continued From page 3 medications.

The findings include:

Review of the facility's policy titled, "Nursing Comprehensive Care Plan", undated, revealed the comprehensive care plan would include items or services ordered, or to be provided. The policy stated the plan of care was designed to maintain the resident or assist the resident to attain his/her highest potential possible. The policy also stated the care plan was prepared by an interdisciplinary team of health care professionals and each resident's care plan was updated based on the target dates used for each goal by the Interdisciplinary team.

Review of Resident #4's record revealed the facility re-admitted the resident, on 12/03/12, with diagnosis which included Atherosclerosis, Renal Failure, Hypertension, Congestive Heart Failure, Carotid Stenosis, Muscle Weakness, and Sinusatrial Node Dysfunction.

Review of Resident #4's Nutrition Care Plan, dated 01/09/13, revealed the facility had determined Resident #4 was at risk for altered nutritional status and had experienced significant weight loss.

Review of the quarterly Minimum Data Set (MDS) Assessment, dated 03/20/13, revealed the facility assessed Resident #4 to have a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact. Review of the Swallowing/Nutritional Status section of the MDS revealed Resident #4 had experienced significant weight loss during the

F 280

Care Planning/Revision

antianxiety, vitamin) will be noted on the care plan, A change in the dose or frequency will be attached to the care plan via a care plan progress note for those already in electronic format, and a written update for those not yet converted. The RD is on site every Monday-Wednesday and every other Friday. She will be responsible for the updates to the nutritional POC, with the exception of every other Friday she is not here. The unit managers will update the dietary care plan as needed during that 5 day interval every 2 weeks

Monitoring will occur via a bi-weekly audit of 3 residents per unit who have changes to or orders for a psychoactive drug, and for 3 residents per unit who have had changes to or orders for supplements, appetite stimulant etc. These audits will be done by the clinical coordinator and the Registered Dietitian. General care plan audits for updated orders (3 per unit per month) will continue to be done by the clinical coordinator but the frequency will increase to every month for at least 2 months (attachments F280 # 3&4 / N192 # 3&4) Results of these audits will be reviewed in the monthly QA meeting 7/9/2013. The frequency of ongoing audits will be discussed/determined at that time

Completion date -- 5/29/2013

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F 280 Continued From page 4 review period. F 280

Review of Resident #4's Physician's Orders revealed an order dated 12/03/12, for Resident #4 to receive a multivitamin daily as a vitamin supplement. Resident #4 was ordered to be weighed at least weekly, on 02/19/13. An additional order was noted, dated 04/04/13, which indicated Resident #4 was to be administered Remeron 30 milligrams (mgs) nightly for depression/appetite. Review of a Physician's Progress Note, dated 04/04/13, revealed Resident #4 was administered Remeron related to depression and decreased appetite.

Continued review of Resident #4's Nutrition Care Plan, revealed the most current goal date listed on the care plan was, dated 03/26/13. Interventions on this care plan included an appetite stimulant Remeron 15 mg to be administered nightly, and weights were to be obtained monthly. Discontinued Interventions listed on the Care Plan included the use of a multivitamin.

Interview with Certified Nursing Assistant (CNA) #2, on 05/09/13 at 10:40 AM, revealed Resident #4 had experienced weight loss over the past few months, and weekly weights were obtained by the CNAs.

Interview with Licensed Practical Nurse (LPN) #1, on 05/10/13 at 11:45 AM, revealed Resident #4 received Remeron 30 mg nightly as an appetite stimulant/anti-depressant and a multivitamin every morning as a dietary supplement. LPN #1 also reported Resident #4 was weighed weekly related to his/her nutritional status. LPN #1

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F 280 Continued From page 5 F 280

stated new or discontinued Physician's Orders were reviewed daily by the Unit Managers and they were responsible for updating the care plans with the new orders..

Interview with Unit Manager #1, on 05/10/13 at 1:28 PM, revealed the Dietician was responsible for updating Nutrition Care Plans, but the Unit Managers updated other plans of care as needed on a dally basis. After review of Resident #4's Nutrition Care Plan, Unit Manager #1 stated the Remeron dosage listed on the plan of care was incorrect. In addition, the Unit Manager stated Resident #4 was weighted weekly instead of monthly as indicated on the Nutrition Care Plan. The Unit Manager reported Resident #4 also received multivitamins which were marked as discontinued on the current Nutrition Care Plan.

Interview with MDS Nurse #1 and MDS Nurse #2, on 05/10/13 at 2 PM, revealed the Dietician was responsible for revising the Nutrition Care Plan. The MDS Nurses reported they were unsure how often nutrition care plans were audited for accuracy, but stated the Dietician visited the facility two (2) or three (3) days per week. The MDS Nurses reported updates to care plans were completed during the quarterly, annual or significant change MDS assessments by the MDS Nurses. However, the Unit Managers were responsible to update the care plans on a daily basis based on daily order changes.

Interview with the Registered Dietician, on 05/10/13 at 2:45 PM, revealed she was responsible for updating the Nutrition Care Plans. The Dietician reported she did not update the care plans on an ongoing basis, but conducted

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F 280 : Continued From page 8 F 280

updates to care plans once per quarter "unless something major changed". The Dietician reported an example of a major change included a change in the resident's medication or supplement. The Dietician reported she did not remember when the last update of Resident #4's Nutrition Care Plan was conducted, but stated if the goal date was 03/26/13, then the care plan was past due for a revision. The Dietician was not sure how the needed revisions to Resident #4's Nutrition Care Plan was not completed.

Interview with the Director of Nursing (DON), on 05/10/13 at 4:40 PM, revealed the Dietician was responsible for updating Nutrition Care Plans on an ongoing basis. The DON stated care plans should be current, so ordered care was followed.

2) Review of Resident #4's record revealed the facility re-admitted the resident, on 12/03/12, with diagnosis which included Atherosclerosis, Renal Failure, Hypertension, Congestive Heart Failure, Carotid Stenosis, Muscle Weakness, and Sinusatrial Node Dysfunction.

Review of the quarterly Minimum Data Set (MDS) Assessment, dated 03/20/13, revealed the facility assessed Resident #4 to have a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.

Review of the section I (Active Diagnosis) of the MDS revealed Resident #4 did not have a diagnosis of Anxiety, Depression, or Mood Disorder at the time of the assessment.

Review of Resident #4's Physician's Orders revealed an order, dated 04/04/13, for Ativan 0.5 mgs every four (4) hours as needed for Anxiety.

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F 280 : Continued From page 7

Another order, written 04/04/13, revealed Resident #4 received Remeron 30 mg at bedtime for Depression.

Review of a Physician's Progress Note, dated 04/04/13, revealed Resident #4 was seen by the Physician due to anxiousness. The Physician diagnosed Resident #4 with Anxiety and ordered Ativan to begin. The note also indicated Resident #4 was diagnosed with Depression, and an order was written for Remeron to be increased related to signs and symptoms of Depression.

Review of Resident #4's Comprehensive Plan of Care revealed he/she did not have a care plan that addressed the Resident's psychiatric conditions (Depression/Anxiety) and needs related to these conditions. There was also no psychiatric drug care plan, to alert staff to monitor for side effects of psychiatric medications such as Ativan and Remeron. The use of Remeron as a nutritional supplement was included on the Nutrition Care Plan, however the dosage was listed as 15 mgs instead of the 30 mgs. Remeron was also listed as an intervention on the Insomnia Care Plan, which was not the diagnosis for use. Yet, there was no care plan addressing the use of Remeron as an anti-depressant. In addition, the use of Ativan was listed as a risk factor for falls on the Fall Care Plan, but was not included in the plan of care as an intervention to help with Anxiety.

Interview with Licensed Practical Nurse (LPN) #1, on 05/10/13 at 11:45 AM, revealed floor nurses did not create or revise care plans. LPN #1 stated the Unit Managers updated the care plans on a daily basis after reviewing Physician's Order from :

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F 280 Continued From page 8  
the previous day.

F 280

Interview with Unit Manager #1, on 05/10/13 at 1:28 PM, revealed the MDS Nurses or the Unit Managers were responsible for creating or updating care plans as needed. Unit Manager #1 reported the MDS Nurses audited the care plans quarterly during the MDS assessment window. Unit Manager #1 stated she had updated Resident #4's Comprehensive Plan of Care to include the use of psychiatric medications. Unit Manager #1 stated she added the use of Remeron to Resident #4's Insomnia Care Plan due to Anxiety at night. Furthermore, Unit Manager #1 stated Resident #4 did not need a mood care plan related to Anxiety or Depression because the diagnosis "does not offset daily living". As for the Ativan, Unit Manager #1 stated she had added the medication as a risk for falls on the falls care plan. She stated there was no need for a specific psychiatric medication care plan because floor nurses monitor for side effects on all medications.

Interview with MDS Nurse #1 and MDS Nurse #1, on 05/10/13 at 2 PM, revealed the Unit Managers were responsible for revising care plans on a daily basis. The MDS Nurses reported Unit Managers initiated new care plans as needed. The MDS Nurses reported they were responsible for updating care plans during MDS assessments which was at least quarterly.

Interview with the DON, on 05/10/13 at 4:40 PM, revealed Unit Managers were responsible for updating care plans on an ongoing basis. The DON stated care plans should be current, so ordered care was provided. The DON reported

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F 280 Continued From page 9  
Resident #4 was prescribed Remeron related to Depression and decreased appetite, but stated the medication was included as an Intervention on the Insomnia Care Plan due to Remeron helping with sleep as well. The DON also reported Resident #4 was ordered Ativan related to Anxiety, but stated she was not sure if a psychiatric medication or mood care plan was needed. The DON was unsure what systems were in place to ensure psychiatric medications and psychiatric diagnosis were care planned when initiated after an MDS assessment had passed.

F 280

F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

F 315 F 315 Prevent UTI  
- LPN #5 was reeducated by the DON on the facilities catheter care policy on 5/9/2013.  
- Resident #1 has subsequently (beginning 5/9) had pericare/cath care performed following the facility policy for catheter care. She has had no further indicators of potential infection. Her physician is aware of the procedural error and no new orders were given.  
- As stated in the CAUTI guidelines and referenced in the survey manual, "most residents with indwelling catheter for greater than seven days will have bacteraemia. The nursing staff has and will continue to monitor all incontinent residents or those with an indwelling catheter for any signs/symptoms of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide appropriate treatment and services to prevent Urinary Tract Infections (UTI's) related to Improper Infection control techniques during Urinary Catheter care for (1) of twenty-five (25) sampled residents (Resident #1).

Continued .....

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/10/2013
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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 315 Continued From page 10

Resident #1 had a History of UTI's and observation of Urinary care for this resident revealed poor Infection control technique.

The findings include:

Review of the facility's "Foley Catheter Care" Policy, revised 06/25/09, revealed the catheter/meatal junction was a significant portal of entry for bacteria into the urinary tract, potentially causing urinary tract infections. The protocol included; starting at the catheter-meatal junction, wash tubing, labia for women and meatus, using friction and a circular motion work outward toward the surrounding perineum. Always work from the area of least contaminated to more contaminated and always work front to back, clean the catheter from the meatus down at least four (4) inches, rinse area with clean warm water and pat dry.

Review of Resident #1's medical record revealed diagnoses which included Senile Dementia, Chronic Kidney Disease, Neurogenic Bladder and Urinary Tract Infections. Review of the Comprehensive Plan of Care, dated 08/03/12, revealed Resident #1 had an indwelling Urinary Catheter related to the diagnosis of Neurogenic Bladder. The goal stated the resident would remain free from UTI complications, and would remain free from any complications related to the use of the Catheter. The interventions included; staff to provide Incontinence care/peri-care/Catheter Care per facility protocol. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/12/13, revealed the facility assessed the resident as having a Brief

F 315 F 315 Prevent UTI cont.

- All nurses were reeducated by the DON with demonstration on the facilities catheter care policy. This took place the week of May 27<sup>th</sup> to May 31<sup>st</sup>.
- All CNA's were reeducated by the DON with return demonstration on catheter care and male and female peri care. This took place the week of May 27<sup>th</sup> to May 31<sup>st</sup>. (attachment F 315, F 441/N214 N144 # 1&2)
- All residents with catheters or incontinence could be affected.
- Pericare is and will continue to be observed routinely during the course of each shift by the nurses in charge of each unit.
- Any employee failure to follow facility policies is subject to discipline up to and including termination.
- A catheter care audit will be done monthly by the unit managers. This audit encompasses all of the elements from the catheter care policy especially focusing on cleaning from the meatus down the catheter 4 inches and using a new area of the cloth if more than one pass is needed. (attachment F 315, F 441/N214 N,144 #3)

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NAME OF PROVIDER OR SUPPLIER  BAPTIST CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071	
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F 315	<p>Continued From page 11</p> <p>Interview for Mental Status (BIMS) of a thirteen (13) out of fifteen (15). Further review revealed the facility assessed the resident as having an indwelling catheter, and having a UTI in the past thirty (30) days.</p> <p>Further review of the medical record revealed a urine specimen was collected on 02/28/13 and the results were reported on 03/03/12 as Pseudomonas Aeruginosa and Providencia stuartii. New Physician's Orders were received on 03/03/13 for Bactrim DS (antibiotic medication) twice a day for five days and Levaquin 750 milligrams (mg's) (antibiotic medication) for five days for a UTI.</p> <p>A urine specimen was collected on 04/17/13 and the results were reported on 04/19/13 as Proteus Mirabilis. New Physician's Orders were received on 04/19/13 for Bactrim DS every twelve (12) hours for a UTI.</p> <p>A urine specimen was collected on 05/08/13 and the results were reported on 05/08/13 as bacteria which was TNTC (too numerous to count). New Physician's Orders were received on 05/08/13 for Clpro 250 mg's (antibiotic medication) every 12 hours related to the results of the urinalysis.</p> <p>Observation, on 05/09/13 at 11:30 AM, of indwelling urinary catheter care for Resident #1, revealed Licensed Practical Nurse (LPN) #5 performed pericare, and then using a new wet wash cloth cleansed the Urinary Catheter tubing from meatus down. The LPN, then using the same wash cloth and cleaned the tubing towards the meatus. Further observation revealed the LPN dried the tubing back and forth from meatus</p>	F 315	<p>The audit will involve four residents with catheters. Audit results will be reviewed/analyzed in the August QA meeting. The frequency of further audits will be determined at that time.</p> <p>Completion Date 05/31/2013</p>

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F 315: Continued From page 12  
down, and then towards the meatus. F 315

Interview with LPN #5, on 05/09/13 at 11:35 AM, revealed the nurse did not realize it was an infection control issue to wipe the Urinary Catheter tubing in both directions, once she had cleansed the tubing from meatus down.

Interview with the Director of Nursing (DON), on 05/10/13 at 5:30 PM, revealed the Foley Catheter tubing should only be cleansed in one direction, from meatus downward.

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

F 441 F 441 Infection Control

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

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

- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
  - (2) The facility must prohibit employees with a communicable disease or infected skin lesions

- LPN #5 was reeducated by the DON on the facilities catheter care policy on 5/9/2013.
- Resident #1 has subsequently (beginning 5/9) had pericare/cath care performed following the facility policy for catheter care. She has had no further indicators of potential infection.
- Resident #1 has had no further symptoms of UTI and no evidence of a wound infection. Her physician is aware of the procedural errors and no new orders were given.
- All nurses were reeducated during the week of May 27<sup>th</sup> to May 31<sup>st</sup> with demonstration on the facilities catheter care policy. (Attachment F 315, F 441/N214 N144 #1 & #2)

Continued...

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F 441 Continued From page 13

from direct contact with residents or their food, if direct contact will transmit the disease.

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

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

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for two (2) of twenty-five (25) sampled residents (Residents #1 and #8).

Observation of indwelling urinary catheter care for Resident #1 revealed poor infection control technique

Observation of dressing changes for Resident #1 and #8 revealed poor infection control technique.

In addition, bread and crackers were not properly sealed and stored in the food cabinet in the medication room on the fourth floor.

The findings include:

F 441 F 441 Infection Control cont.

- LPN #7 was reeducated by the DON on the facility policy for Clean Dressing Change Technique (APIC infection control manual - Section G nursing policies, page G10) by the DON on May 9<sup>th</sup>.
- Resident #8 Did not and has not shown any signs or symptoms of infection related to the dressing change noted. The physician is aware of the procedural error and no new orders were noted.
- All residents with a catheter or wound could be affected by the examples noted in the SOD.
- The facility maintains an active Infection Prevention and Control program. Inservices are mandatory for all employees each year including but not limited to hand washing, isolation precautions, disease transmission, cleaning protocols, food prep and TB. A review of these standards will be given to all nursing staff on 6/10/2013 and 6/11/2013. The facility also maintains active surveillance to investigate and prevent to the extent possible the onset and spread of infection. This program is currently run by the DON.

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F 441	Continued From page 14  1. Review of the facility's "Foley Catheter Care" Policy, revised 08/25/09, revealed the catheter/meatal junction was a significant portal of entry for bacteria into the urinary tract, potentially causing urinary tract infections. The protocol included; starting at the catheter-meatal junction, wash tubing, labia for women and meatus, using friction and a circular motion work outward toward the surrounding perineum. Always work from the area of least contaminated to more contaminated and always work front to back, clean the catheter from the meatus down at least four (4) inches, rinse area with clean warm water and pat dry.  Observation, on 05/09/13 at 11:30 AM, of Urinary Catheter Care for Resident #1, revealed Licensed Practical Nurse (LPN) #5 performed perineal care, and then using a new wet wash cloth cleansed the Catheter tubing from meatus down. The LPN, then using the same wash cloth cleaned the tubing towards the meatus. Continued observation revealed the LPN dried the tubing back and forth from meatus down, and then towards the meatus.  Interview with LPN #5 at 11:35 AM revealed she did not realize it was an infection control issue to wipe the Catheter tubing in both directions, once she had cleansed the tubing from meatus down.  Interview with the Director of Nursing (DON), on 05/10/13 at 5:30 PM, revealed the Urinary Catheter should only be cleansed in one direction, from meatus downward.  2. Review of the facility "Procedure for Clean Dressing Technique" from the Infection Control	F 441	F 441 Infection Control cont.  - As part of her daily rounds, the wound nurse will be responsible for observing wound care provided by the staff nurses and correcting procedural errors, providing reeducation as indicated. - A catheter care audit will be done Monthly by the unit managers. (attachment F 315, F 441/N214 N144 #3) The audit will involve four residents with catheters. Audit results will be reviewed/analyzed in the August QA meeting. The frequency of further audits will be determined at that time.  - A Clean Dressing Change audit will be done by the wound nurse on one resident per unit each month for two months (attachment F 441/N144 #4). The results of these audits will be reviewed in the August QA meeting. The frequency of future audits will be determined at that time. - All facility staff have been reminded of the need to date food items and keep them separate. Unit charge nurses and dietary staff responsible for stocking the floors will be responsible for monitoring for compliance.		

Completion date 05/31/2013

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F 441	<p>Continued From page 15</p> <p>Manual for Long Term Care Facilities, undated, revealed the procedure for a dressing change included: wash hands, remove old dressing, remove gloves, wash hands, apply clean gloves, cleanse the wound, measure the wound, remove gloves, wash hands, apply any medication ordered and dress wound.</p> <p>Observation of a dressing change for Resident #8, on 05/08/13 from 10:20 AM until 11:10 AM, revealed LPN #7 cleansed the resident's coccyx wound with Normal Saline, dried the area with a gauze pad, and measured the wound. The nurse then picked up a box of Santyl and took the tube out of the box using her soiled gloves and applied the Santyl to the wound with a cotton applicator. LPN #7 then removed the soiled gloves and washed her hands. Interview with LPN #7 at the time of the dressing change confirmed the Santyl was kept in the treatment cart.</p> <p>3. Observation of a dressing change for Resident #1 on 05/09/13 from 10:00 AM until 10:30 AM revealed LPN #7 removed the soiled dressing from the resident's coccyx wound, and without washing hands, donned new gloves and cleansed the wound with a spray bottle of Wound Cleanser, applied the Alginate Wound Dressing and Foam Dressing, and washed her hands. Interview with LPN #7 during the dressing change confirmed the Wound Cleanser was kept in the treatment cart.</p> <p>Interview, on 05/09/13 at 10:30 AM, with LPN #7, revealed she should have washed her hands after removing the soiled dressings from both Resident #1 and Resident #8, prior to cleansing the wounds. She stated she could see how the supplies could be contaminated if handling them</p>	F 441	

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F 441	Continued From page 16 after removing a soiled dressing, even if the soiled gloves were removed.	F 441		
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Interview with the DON, on 05/10/13 at 5:30 PM, revealed staff should wash hands after removing a soiled dressing and prior to cleansing a wound. She indicated the treatment supplies and medications used would be contaminated if they were handled with soiled gloves or with hands that had not been washed after removing soiled gloves.

4. Review of the facility's policy titled "Storage Guidelines", dated 02/2011, revealed all food items must have the products name and date it was prepared, and discarded within forty-eight (48) hours after it was prepared.

Observation, on 05/08/13 at 9:45 AM, revealed two (2) opened and undated loaves of white bread, and a package of saltines crackers which was opened, and not properly sealed leaving the saltine crackers exposed, and the package was not dated, in a cabinet in the medication room on the fourth floor. Further observation revealed, both of the loaves of bread were grey in color and appeared to be dry.

Interview with LPN #3, on 05/08/13 at 10:00 AM, revealed the loaves of bread had come up from the kitchen and should have been dated. She further stated she did not know who had opened the package of saltine crackers but those should have been dated after they were opened and properly sealed so the crackers were not exposed.

Interview with the Unit Manger, on 05/08/13 at

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F 441	<p>Continued From page 17</p> <p>9:45 AM, revealed the loaves of bread should have been dated when they were sent up to the unit from the kitchen and the saltine crackers should have been dated and sealed so the crackers were not exposed.</p> <p>Interview with the Administrator, on 05/10/13 at 5:40 PM, revealed the loaves of bread should have been dated when they were sent from the kitchen. She stated the facility did not have a policy related to food items in the medication rooms; however, they should have all been dated and sealed to prevent exposure of the food items.</p>	F 441	

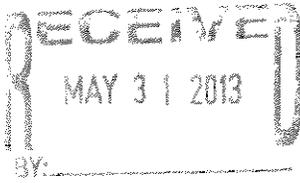
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edtion)</p> <p>Plan approval: 1948, 1967, 1989</p> <p>Facility type: SNF/INF</p> <p>Type of structure: Type I fire resistive construction</p> <p>Smoke Compartment: forty eight (48)</p> <p>Fire Alarm: Complete Fire alarm A Building: Smoke detectors in resident rooms/ Heat detectors in corridors B Building: Smoke detectors in resident rooms/ Heat detectors in corridors C Building: Single station Smoke Detectors in resident rooms/ Smoke detectors in corridors.</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: A Building: Diesel installed 1989 C Building: Diesel installed 1989</p> <p>A standard Life Safety Code survey was conducted on 05/08/13. Baptist Convalescent Center was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred sixty three (163). The facility is licensed for one hundred sixty seven (167).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Donna Fodge, RN* TITLE *Administrator* (X6) DATE *5/31/13*

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

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**K 027 SS=D** NFPA 101 LIFE SAFETY CODE STANDARD

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in smoke barriers, were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect, six (6) of thirty eight (38) smoke barriers, forty eight (48) residents, staff and visitors.

The findings include:

Observation on 05/08/2013 at 11:20 AM, revealed the doors located in the smoke barrier at 4A East had a gap between the doors greater than 1/8 inch. Further observation revealed the same for the smoke barrier doors located 4A West, 3A East, and 3A West. Smoke barrier doors must close while leaving a gap no greater than 1/8 inch. The observations were confirmed with the Maintenance Director.

Interview on 05/08/2013 at 11:20 AM, with the

**K 027**

K 027 Life Safety

- Silicone gaskets have been applied to all smoke barrier doors as cited.
- All smoke barrier doors in the building were inspected. Doors with a 1/8 inch or greater have had silicone gaskets installed.
- All smoke barrier doors will be assessed for proper seal monthly and logged. Doors gaskets in place will also be inspected for damage or wear to the gaskets. Gaskets will be installed/replaced as indicated for gaps of 1/8 inch or greater.

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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	<p>Continued From page 2</p> <p>Maintenance Director, revealed smoke barrier doors are checked on a monthly basis and he had not identified any doors with gaps greater than 1/8 Inch.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027		