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

PRINTED: 06/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505294		03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB CTR - BEACON HI	128 BEACON HILL DRIVE LONGVIEW, WA 98632

(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	F 000	***This plan of correction is the center's credible allegation of compliance.***	
	This report is the result of an unannounced Quality Indicator Survey conducted at Kindred Transitional Care and Rehabilitation Center - Beacon Hill on 3/11/13, 3/12/13, 3/13/13, 3/14/13, 3/15/13 and 3/18/13. A sample of 41 residents was selected from a census of 59 residents. The sample included 34 current residents and 7 former and/or discharged residents.		**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
	The survey was conducted by: Julie Peters, MA Shelly Darnell, BSS Debbie Barette, RN, BSN Phan Pham, RN, BSN		RECEIVED JUN 13 2013 DSHS/ADSA/HCS	
	The survey team is from: Department of Social and Health Services Aging and Long Term Support Residential Care Services, District 3, Unit C & D P.0. Box 45819 Olympia WA 98504-5819 Telephone (360) 884-8420 Fax: (360) 884-8451		IDR AMENDED	
	Residential Care Services Date 6/4/13			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Exec. Dir. | (X6) DATE 6/10/13

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

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to maintain or improve residents functional abilities for 1 of 3 current sampled residents (#3) reviewed for rehabilitative services. This failure placed the resident at risk for a decline in functional abilities. Findings include: Resident #3 was admitted to the facility on [redacted]12 with diagnosis to include a right hip and arm fractures. The Minimum Data Set (MDS), an assessment tool, dated on 12/21/12 indicated the resident required extensive with activities of daily living skills to include, bathing and personal hygiene tasks. Record review revealed Resident #3 participated in skilled physical and occupational therapy services from 9/13/12 through 12/2/12. On 12/3/12 per referral of the physical therapist, Resident #3 started a restorative nursing rehabilition program to maintain her level of function. Resident #3's restorative nursing program included seated knee bends, marching, ankle pumps, buttocks squeezes, transfer practice, and ambulation to and from meals. The program was to be completed 6-7 days weekly.	F 311	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." **F311** **A) Resident #3 will have her RA program reviewed to make sure it is appropriate for meeting her current needs. After review the program will be implemented, followed, monitored and updated as needed.** **B) Residents on RA programs will have their programs reviewed making sure it is appropriate for meeting their needs. After review the program will be implemented, followed, monitored and updated as needed.** **C) RA programs will be reviewed quarterly or due to significant change to make sure It is adequate to meet the needs of the residents.** **D) RA Program Manager will randomly audit the programs and compare to the function of the resident to make sure needs are met. Results of the audit will be reported back to PI on a monthly basis to gauge compliance with these changes. ED responsible for overall compliance.**	4/24/13 **24-Apr-13** **24-Apr-13** **24-Apr-13** **24-Apr-13**

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F 311	Continued From page 2 Review of the facilities documentation of Resident #88's restorative program revealed she had participated 16 days in December, 17 days in January, 20 days in February and 6 of 14 days in March. There was one documented day resident refused to participate in her daily restorative program. On 3/13, 3/14 and 3/15, Resident #3 was observed being taken in her wheel chair to the dining room for lunch. On 3/15/13 at 12:15 p.m., Resident #3 stated she liked to participate in the restorative program and felt continued therapy made her stronger. The resident stated was not offered to participate in the restorative program daily. At 12:30 p.m., Restorative Nursing Assistant (RA) stated, "She (Resident #3) has been decreasing a little bit on her knees." The RA stated she was frequently pulled to work on the floor to do patient care and was unable to do assistant residents with their restorative nurse program. At 1:00 p.m., the Director of Nursing (DNS) stated, "the RA has been pulled to work the floor ... We do see things we need to work on with the RA program. We now have a full staff and we are working on it." Failure to provide adequate restorative nursing interventions placed the resident at risk for a decline in physical function.	F 311	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an environment free of accident hazards for Hoyer lift transfers for 1 of 2 sampled residents (#135), wheelchair was locked for 1 of 2 sampled residents (#146), and combustible material was not placed near baseboard heaters for 3 of 6 resident rooms. These deficient practices placed residents at risk for sustaining avoidable injury. Findings include: Hoyer lift: RESIDENT #135: Resident #135 was alert. He had recently had a [redacted] His wife was interviewed 3/13/19 at 10:00 a.m. Her husband had fallen from his Hoyer lift on 3/10/13 when a strap broke from his sling. Her husband was eased to the floor by the nurses' aides who were transferring her husband. She was notified of the fall and the doctor did an x-ray of his back which showed nothing was broken.	F 323	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." **F323** **A) Resident #135 was assessd by nursing and had x-rays done on 3/10/13 to make sure that no injury was sustained. Hoyer slings were pulled and inspected by ED and DNS to make sure no other worn slings were left on the floor. Worn slings were removed from operation and new ones were ordered on 3/11/13 with new slings arriving 3/14/13. Baseboard heaters for resident 79,45 and 84 were disconnected from power. Heat to be provided by existing HVAC system and ambient floor heat. Resident #146 will have his wheelchair wheels locked on both sides prior to transfer.** **B) Hoyer slings were pulled and inspected by ED and DNS to make sure no other slings were left on the floor. Worn slings were removed from operation and new ones were ordered on 3/11/13 with them arriving on 3/14/13. Baseboard heaters were reviewed for compliance with the 30 inch rule as identified by the Fire Marshall and disconnected from power if they could not meet that criteria. Heat to be provided by existing HVAC system and ambient floor heat. Residents will have their wheelchair wheels locked on both sides prior to transfer.**	4/24/13 24-Apr-13 24-Apr-13

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F 323	Continued From page 4 Licensed nurse (LN) A was interviewed on 3/13/13 at 9:20 a.m. She said the Hoyer lifts were checked by maintenance and the slings for the Hoyer lift were washed daily by laundry personnel. She had not heard of a sling strap breaking before but since the incident heard there was going to be training about this. The Maintenance Director was interviewed on 3/13/13 at 10:06 a.m. He said he checked the inner workings of the Hoyer lift monthly but did not inspect the slings used to transfer the residents. LN B was interviewed on 3/13/14 at 10:14 a.m. The nurse said, "I think maintenance replaces the slings for the Hoyer lifts and the sit to stand transfer bars." The nurse went on to say she was aware of the incident where the sling strap broke. The nurse then said, "I know maintenance checks the inner workings of the Hoyer lifts but nursing uses the slings for the residents." The Director of Nursing Services (DNS) was interviewed on 3/13/14 at 10:34 a.m. The DNS stated "as a result of the incident the facility was setting up a training to ensure all nursing staff were checking the lift slings for the Hoyer lift and sit to stand bars for safety." The DNS also stated "the facility was also putting in to place a preventative maintenance schedule in place to replace slings after so many hours of use." The Staff Development Nurse (SDN) was interviewed on 3/13/13 at 10:45 a.m. On hire all staff were trained on how to use the Hoyer lift and sit to stand bars. Maintenance checked the inner	F 323	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." **F323 - Con't.** **C) NAC's will attend in-service on company's newest lift video, as well as be instructed on how to identify a worn sling and what to do if one is found. They will also review stand pivot transfers with wheelchairs on proper protocol. Laundry staff will be in-serviced on care and maintenance of hoyer slings, as well as how to identify a worn sling and what to do if one is found. ED or designee will review slings monthly at same time maintenance does preventative reviews of the lifts. Worn slings will be removed from operation at that time.** **D) SDC or designee will perform random audits of hoyer transfers and wheelchair transfers to gauge compliance with\ these changes and report any deficient practice to monthly PI meeting. ED responsible for overall compliance.**	24-Apr-13 24-Apr-13

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F 323	Continued From page 5 workings of the lifts but did not check the slings. She said she had scheduled a training on 3/21/13 reminding employees to inspect the transfer slings used for lifts. The Executive Director was interviewed on 3/13/13 at 11:04 a.m. As a result of the incident nursing staff were being required to label the slings when they were put in to service. The facility was requiring laundry services to be aware of what to look for in the slings and report any changes in the sling to the nursing supervisor. Slings were going to be replaced as required by the manufacturer's recommendations or if they began to show signs of wear. Nursing Assistant (NA) C was interviewed on 3/13/13 at 11:34 a.m. She was aware of the incident with Resident #135. She said to her knowledge no resident had fallen from a sling strap breaking before. All resident lift transfers were done with two staff per facility policy with any lifts. She was glad the facility was going to implement a formal process with which to track the slings being used for resident transfers. LN D was interviewed on 3/13/14 she said prior to the incident with the sling strap breaking during the transfer lift for Resident #135 no formal process was in place to ensure the slings were safe to use. Record review was done. Resident #135 was being transferred with a Hoyer lift on 3/10/13 during the transfer one of the sling straps broke. The two NAs doing the transfer eased the resident to the floor. The resident's wife and doctor were notified of the incident. X-rays were	F 323	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 323	Continued From page 6 ordered for the resident which did not show any injury to the resident as a result of the fall. The resident's care plan was clearly marked for staff to check the integrity of the sling before using the slings for any resident transfer. Baseboard heaters: RESIDENT #79 On 3/13/13 at 2:25 p.m. Resident #79 was sleeping in bed and covered with a blanket. The resident's bed was placed against the wall and was approximately five inches above the baseboard heater. The resident was not interviewable. RESIDENT #45 On 3/13/13 at 3:40 p.m. Resident #45 was sleeping in bed and covered with a blanket. The resident's bed was at the lowest position and approximately four inches from the baseboard heater. The resident's blanket was about two inches from the baseboard heater. The resident stated she did not pay attention to the heater and did not know if the heater was turned on. At 3:42 p.m. the baseboard heaters in resident #79 and #45 rooms were not hot. The baseboard heater in Resident #79's room had a manufacture sticker of recommendation clearance which stated combustible items must be maintained at least 12 inches from the baseboard unit. RESIDENT #84	F 323	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 323	Continued From page 7 On 3/13/13 at 3:45 p.m. Resident #84 was sleeping in her bed and the baseboard heater in her room was on. A garbage can with paper inside and a plastic bag folded to the outside of the can were observed. The garbage can and a furry pair of boots were leaning against the heater. At 3:50 p.m. the Maintenance Director said some of the rooms had baseboard heaters and were rated 110F degrees. The Maintenance Director said staff would have to assist the residents to turn on the baseboard heaters and all the baseboard heaters worked. At 4:00 p.m. NA L said the baseboard heater in Resident #84's room was hot. NA L confirmed there was a pair of furry boots and a garbage can leaning against the heater. NA L said some of the rooms had baseboard heaters and thermometer dials. NA L stated she would turn on the heater if the residents complained of being cold. Wheelchair: On 3/13/13 at 10:10 a.m. NA M and NA N used a Hoyer lift and assisted to transfer Resident #146 from the resident's wheelchair to the resident's bed. The NAs did not lock the resident's right wheelchair's wheel. At 11:00 a.m. NA N said wheelchair was supposed to be locked. NA N stated she was not aware one of the wheels was not locked. NA N said she had been trained to lock the wheelchair during transfers.	F 323	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		4/24/13

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F 431	Continued From page 8 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 431	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." **F431** **A) Expired dressing change kits, lab speciman containers and swabs, aspirin and barbarairzine hydochloride have been discarded per company policy.** **B) Expired dressing change kits, lab speciman containers and swabs, aspirin and barbarairzine hydochloride have been discarded per company policy.** **C) LNs will be in-serviced on review of expiration dates and proper disposal of expired items per company policy.** **D) DNS or designee will randomly inspect medication carts and medication rooms to identify compliance with this change and report any deficient practice to monthly PI meeting. DNS responsible for overall compliance.**	 **24-Apr-13** **24-Apr-13** **24-Apr-13** **24-Apr-13**

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F 431	Continued From page 9 review, the facility failed to implement procedures to ensure that expired medications and/or medical supplies were not stocked in the medication storage rooms for 2 of 2 medication rooms and 1 of 3 medication carts. This failure placed residents at risk of receiving expired medications and/or supplies. Findings include: <Third Floor Medication Storage Room On 03/14/13 at 11:11 a.m., the third floor medication storage room was inspected in the presence of Resident Care Manager A and was found to contain nine dressing tray kits for Intravenous lines with an expiration date of October 2012. <Second Floor Medication Storage Room On 03/14/13 at 11:50 a.m., the second floor medication storage room was inspected in the presence of Licensed Nursed (LN) H. Expired medical supplies were found including four bottles of Bactec Anaerobic (culture vials) which had expired on 03/31/2011, 11/30/2012 and 07/31/12. Also found were Culture swabs which had expired on 10/2009, 11/2011, and 01/2012, specimen collection tubes which expired on 05/2012, and 3 sets of blood collection tubes with expiration dates of 12/2011 and 05/2012.	F 431	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 431	Continued From page 10 At 12:01 p.m., when asked how the facility ensures that expired medical supplies are not used during patient care, LN H stated, "When a nurse draws a specimen they should check the date on the supplies. If supplies are expired they should throw it out. <3rd Floor Medication Cart-South On 03/14/13 at 2:30 p.m., the third floor medication cart in the south wing was inspected in the presence of LN G. The cart contained a bottle of Aspirin 325 mg which had expired 02/2013. The cart also contained a half empty bottle of Barbarairzine Hydochloride tablets which had expired 07/2012. LN G stated the open date of the bottle had been 09/21/2012 as indicated by the written date on the bottle. The LN confirmed the medication had expired before it was opened for patient use. The cart contained a bottle of lidocane without a resident name or date it was first used. LN G stated, "the resident is done with that. It should have been thrown away." When asked if there is a policy to ensure expired medications were not given to residents, LN G stated, "I am not aware of a schedule, but I look at expiration dates before I give them." 03/15/13 at 10:05 a.m. the Director of Nursing (DNS) was interviewed regarding Medication Storage. When asked how the facility ensured that	F 431	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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	505294		03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB CTR - BEACON HI	128 BEACON HILL DRIVE LONGVIEW, WA 98632

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F 431	Continued From page 11 residents were not given expired medication the DNS stated, "Our central supply person looks at dates when supplies are delivered to storage rooms and carts, the nurses also look, and the pharmacy consultant checks medications in carts and rooms on a quarterly basis. When asked how the facility ensures that medical supplies including blood vials and tray kits are not used after the expiration dates, the DNS stated, "Nurses are to check those before use, especially for vials and for cultures."	F 431	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	**F441** **A) Resident #88 will receive proper peri-care and catheter care per company policy to prevent possible infection. Holding tank will be added to hot water heater that supplies the employee bathroom and kitchen area with additional supply of hot water.** **B) Residents with catheters will receive proper peri-care and catheter care per company policy to prevent possible infections. Holding tank will be added to hot water heater that supplies the employee bathroom and kitchen area with additional supply of hot water.** **C) NACs will receive in-service on catheter care per company policy. Holding tank and re-circulating pump will be installed by licensed plumber to code.** **D) SDC or designee will perform random audits of catheter care to ensure compliance with change and report any deficient practice to monthly PI meeting.**	4/24/13 **24-Apr-13** **24-Apr-13** **24-Apr-13** **24-Apr-13**

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F 441	Continued From page 12 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 staff members (NAs J & K) changed gloves during personal care of residents in a manner to prevent the spread of infection. Additionally, the facility failed to ensure appropriate water temperatures in the employee bathroom on the 3rd floor and the hand washing sink in the facilities kitchen. These failures placed residents at risk for contracting disease and infection. Findings include: <Personal Care> On 3/13/13 at 2:40 p.m. Nursing Assistant (NA) J put on gloves and provided catheter (tube placed in the resident's bladder to help drain urine) and personal care to Resident #88. NA J held the	F 441	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." **F441 - Con't.** **Maintenance Director or designee will perform water temperature checks as part of preventative maintenance program to ensure that additional supply is allowing for proper water temperatures and report deficiencies to monthly PI meeting. ED is responsible for overall compliance.**	24-Apr-13

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F 441	Continued From page 13 catheter at the tip of the resident's penis with her left thumb and her index finger. NA J wiped the catheter with her right hand with a wash cloth and let go of the catheter. NA J repositioned the resident's penis to his left side with her left hand and wiped the resident's right inner thigh with her right hand. NA J repositioned the resident's penis and the catheter to the right side and wiped the resident left inner thigh with her right hand. NA J touched the catheter with her contaminated left hand. NA J did not wipe the resident's penis or part of the catheter where she held with her left thumb and index finger. While wearing the contaminated gloves NA J pulled up the resident's brief, pants and blanket. NA J grabbed the bed control, adjusted the resident's bed and pulled the curtain open. At 2:55 p.m. NA J stated she did not change gloves during the process. NA J said she usually changed gloves after she finished with the resident. When NA J was asked about glove change protocol during care NA J said "I did exactly how I was taught." On 3/14/13 at 9:48 a.m. NA K put on gloves and provided catheter and personal care to Resident #88. NA K wiped the resident's inner thighs with her right hand with a wash cloth. NA K held the catheter with her left hand and wiped the resident's penis with her right hand. NA K held the catheter at the tip of the resident's penis and wiped the catheter at the direction away from the penis. NA K lifted the catheter with her left hand and wiped the resident's scrotum. NA K contaminated the catheter with her left hand. NA K assisted the resident turn to the resident's right side. NA K wiped the resident's buttocks and	F 441	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 441	Continued From page 14 between the buttocks. NA K pulled up the resident's brief, pants and blanket with the contaminated gloves. At 10:00 a.m. NA K said she did not change gloves after wiping the resident's buttocks and she should have. On 3/15/13 at 9:25 a.m. the Director of Nursing Services (DNS) said staff members had been in serviced and had competency skills checked off when they were hire, yearly and as needed. The DNS stated when the Licensed Nurses (LNs) noticed issues during care the LNs brought forward to the Staff Development Nurse (SDN) and staff members were in-serviced. At 11:00 a.m. the SDN stated it was her responsibility's to provide infection control education to staff members. The SDN said staff members had been in-serviced on catheter care and infection control when they were hire and had their skills checked off. The SDN said she looked at the infection control log for trends and provided in-service accordingly. Refer to F-441 <Water Temperature> On 3/15/12 at 9:30 a.m., the water temperature in the employee bathroom on the third floor of the facility was 79.5 degrees after several minutes of running the hot water. At 9:40 a.m., the hand washing and food prep sinks in the facilities kitchen was 95.3 degrees after several minutes of continually running the	F 441	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 441	Continued From page 15 hot water. At 9:45 a.m., the facilities Maintenance Director (MD) stated the kitchen and the employee bathroom both used the kitchen water heater. The water heater was replaced about a year ago. The MD stated, "It's (the kitchen sinks and employee bathroom sink) are on a 110 gallon tank, basically, it runs out of hot water. Our company standard for the kitchen is the water should be 140 degrees."	F 441	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have 80 square feet per resident in multiple resident rooms for 8 of 22 resident rooms (Rooms 302, 303, 305, 306, 307, 308, 310 and 311) located on the third floor. Findings include: In previous full surveys, resident rooms 302, 303, 305, 306, and 307 measured 157 square feet or 78.5 square feet per resident. Resident rooms 308, 310, and 311 measured 144 square feet or 72 square feet per resident. Observation on 3/13/13 at 9:30 am and interview with administrative staff on at 3:11 pm revealed	F 458	**F458** **A) All residents currently in Rooms 302, 303, 305, 306, 307, 308, 310 and 311 are assessed for equipment, mobility and function, along with roommate compatibility before placement is made. (IDT)** **B) Any resident considering Rooms 302, 303, 305, 306, 307, 308, 310 and 311 are assessed for equipment, mobility and function, along with roommate compatibility before placement is made. (IDT)** **C) IDT reviews these rooms on a ongoing basis to meet these needs of residents.** **D) Any room issues are brought up in stand up meeting and alternatives are looked at to rectify the situation. ED is responsible for overall compliance.**	4/24/13 **24-Apr-13** **24-Apr-13** **24-Apr-13** **24-Apr-13**

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F 458	Continued From page 16 no changes in the room square footages from previous surveys.	F 458	**DISCLAIMER STATEMENT:** "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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