STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185196	A. BUILDING _____ B. WING _____	**06/17/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED NURSING AND REHABILITATION-BASHFORD	**3535 BARDSTOWN ROAD LOUISVILLE, KY 40218**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0160 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Follow policies and procedures to convey the resident's personal funds to the appropriate party responsible after the resident's death.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to convey upon death, the personal funds deposited with the facility to the individual or probate jurisdiction administering the resident's estate as provided by State Law within thirty (30) days for one (1) resident account out of five (5) reviewed resident accounts, Unsampled Resident A. The resident's trust fund balance deposited with the facility for Unsampled Resident A was applied to the resident's funeral bill and not conveyed to the legal representative. Further, the funds were applied after the thirty (30) day period provided by State Law. The findings include: Review of the facility's policy regarding Resident Trust Statements/Discharges and Medicaid Eligibility, dated [DATE], revealed the facility was to have disbursed the resident funds within thirty (30) days of the resident's death. The facility was required to refund the resident funds to the individual, stated agency, or probate jurisdiction administering the estate. Review of the facility's records pertaining to the conveyance of personal funds for expired residents revealed the facility released the personal funds for Unsampled Resident A forty (40) days after the resident expired. Unsampled Resident A expired on [DATE]. The facility released personal funds for $753.09 to a funeral home on [DATE]. Review of a copy of the check administered from the resident's personal trust fund, dated [DATE], revealed the facility paid $753.09 to the funeral home and cemetery that handled the resident's burial. Interview with the Business Office Manager, on [DATE] at 3:50 PM, revealed the facility released the personal funds for Unsampled Resident A more than thirty (30) days after the death of the resident. The Business Office Manager stated the resident had no estate and the facility was required to send the resident funds to the probate jurisdiction. She further stated the resident's prior Power Of Attorney (POA) had requested the facility make the payment directly to the funeral home who served the expired resident. The Business Office Manager stated the facility had some delay in obtaining a bill from the funeral home, and this resulted in the facility sending the funds to the funeral home in forty (40) days rather than within thirty (30) days. Interview with the Field Accounting Manager, on [DATE] at 3:55 PM, revealed the facility did not send the resident funds to probate when a resident did not have an estate because probate did not accept resident fund checks. She stated the probate would let the check expire, and then the facility would send the money to the expired resident's next of kin. Interview with the Executive Director, on [DATE] at 4:00 PM, revealed Unsampled Resident A's POA requested the facility pay the funeral home with the resident's remaining funds.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to revise care plans for five (5) of twenty-two (22) sampled residents (Residents #2, #4, #7, #8, and #15). The facility failed to revise Resident #2's care plan to include new therapy orders. In addition, the facility failed to revise care plans for Residents #4, #7, #8, and #15 to include interventions to anchor the indwelling catheters. The findings include: Review of the facility's policy regarding Indwelling Catheters, dated 08/31/12, revealed catheter tubing was secured using an anchoring device to prevent movement and urethral traction. 1. Review of the clinical record for Resident #2 revealed the facility admitted the resident with [DIAGNOSES REDACTED]. Review of Resident #2's Annual MDS assessment, completed by the facility on 05/15/15, revealed the facility assessed the resident as requiring total assistance from staff for bed mobility, dressing, and toileting care. Resident #2 also required extensive assistance to complete personal hygiene and required a two (2) person staff assist to transfer with the use of a Hoyer lift. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment and the resident scored a fourteen (14) out of fifteen (15) meaning the resident was interviewable. Review of the Care Plan, dated 08/12/14, for Resident #2, reviewed on 06/15/15 with a target date of 09/07/15 revealed no evidence the care plan was reviewed and revised to reflect new orders for physical therapy. Review of the physician's orders [REDACTED].#2 to receive Physical Therapy. Physical Therapy was to assist the resident up into a wheelchair with a Roho cushion up to one hour at a time, two times per day. Review of the Nurses' Notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse transcribed the physician's orders [REDACTED]. There was no evidence the facility sent a Physical Therapy referral form to the therapy department. Interview with Resident #2, on 06/15/15 at 1:30 PM, revealed he/she was on bed rest and wanted to get out of the bed. Resident #2 stated he/she was unaware the physician had placed an order on 06/10/15 for Physical Therapy to assist the resident to get into a wheelchair twice per day for an hour at a time. The resident stated he/she had not received Physical Therapy since the order was written. Interview with CNA #4, on 06/16/15 at 5:10 PM, revealed the CNA provided care for Resident #2. CNA #2 stated Physical Therapy used to assist Resident #2 to get into a wheelchair, then his/her wounds became worse and the resident's physician placed him/her on bed rest. Interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed she did not update the care plan for Resident #2 after the physician ordered Physical Therapy on 06/10/15. She stated she should have updated the care plan for Resident #2 when the Interdisciplinary Team read those orders at morning meeting. 2. Review of Resident #8's clinical record revealed the facility readmitted the resident on 12/11/14, with the [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly MDS assessment, completed on 05/07/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #8, dated 06/25/13, with goal revision on 02/18/15 and the target date of 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, [MEDICAL CONDITION] (swelling), and an indwelling catheter. The care plan included the resident was at risk for

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.

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KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) complications associated with [MEDICAL CONDITION], imitated on 06/25/13, and goal target date was 08/27/15. Interventions listed on the care plan included: ensuring the catheter tubing was positioned properly; and, monitor for signs and symptoms of injury, infection or ulcers. Observation, on 06/17/15 at 2:45 PM, revealed during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP), when Resident #8 requested the ARNP to look at his/her left posterior thigh. The indwelling catheter tubing was not anchored. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM, revealed he was not aware if positioning of the catheter tubing was on the care plan. The tubing was supposed to be anchored and not laid on by the resident. Anchoring the tubing keeps the resident from laying on the tubing. Interview with Resident #8, on 06/17/15 at 3:05 PM, stated the indwelling catheter tubing was anchored at times and other times was not anchored. 3. Review of Resident #4's clinical record revealed the facility admitted the resident on 06/10/13, with [DIAGNOSES REDACTED]. Review of Resident #4's quarterly MDS assessment, completed on 05/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as an eleven (11) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan, dated 03/31/15, for Resident #4 revealed goal revisions on 05/20/15 and the target date of 08/27/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe urine for changes in characteristics, foul odor, and pain; and, provide catheter care every shift. Observation, on 06/17/15 at 3:40 PM, with Certified Nursing Assistant (CNA) #3 present, revealed Resident #4's indwelling catheter bedside drainage bag was placed in a dignity bag on the resident's left side of the bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying on top of the resident's thigh area, no skin breakdown was noted. Interview with CNA #3, on 06/17/15 at 3:40 PM, revealed indwelling catheter tubing was supposed to be anchored to the resident's leg to prevent the catheter tubing from moving. Interview with Resident #4, on 06/17/15 at 3:40 PM, revealed the indwelling catheter tubing had been anchored to his/her leg with tape at times. 4. Review of Resident #15's clinical record revealed the facility admitted the resident on 10/08/14, with [DIAGNOSES REDACTED]. Review of Resident #15's Quarterly MDS assessment, completed on 04/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan, dated 10/28/14, for Resident #15 revealed a target date of 07/23/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe for urinary tract infection; monitor intake and output; and, monitor for pain and discomfort. Observation, on 06/17/15 at 3:45 PM, with Registered Nurse (RN) #1 present, revealed Resident #15's indwelling catheter bedside drainage bag was placed in a dignity bag on the resident's left side of the bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying on top of the resident's left thigh, no skin breakdown was noted. Interview with RN #1, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to the resident's leg to keep the catheter tubing in place and to keep the resident from laying on the tubing. Interview with Resident #15, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to his/her leg with tape. 5. Review of Resident #7's clinical record revealed the facility admitted the resident on 08/22/14, with [DIAGNOSES REDACTED]. Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, completed on 05/11/15, revealed the facility assessed the resident during a Brief Interview of Mental Status (BIMS) as two (2) of fifteen (15), which meant the resident was not interviewable. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 08/26/14. Problems on the care plan included the resident was at risk for falls related to increased fall risk score, poor cognition, poor safety awareness and past attempts to get out of bed unassisted. In addition, the care plan included the resident was at risk for skin breakdown related to current pressure area, decreased mobility and history of decreased nutritional intake. The care plan also stated that Resident #7 care plan meet his/her own daily care needs without assistance from staff. The care plan had an intervention related to daily care needs of an indwelling catheter to bedside drainage. There was no indication that the catheter should be anchored to his/her leg. Observation, on 06/16/15 at 3:20 PM, revealed Resident #7 was laying in the bed with a drainage bag placed on the resident's left side of the bed. Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy included the indwelling catheter tubing should be anchored to maintain positioning, to keep the tubing from being under the resident. She stated the intervention to anchor the indwelling catheter was not included on Resident's #4, #7, #8 and #15 care plans; however, it was the policy, as well, and should have been included on the care plans. Continued interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed she would review and update care plans as appropriate per the information from the physician's orders [REDACTED].
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy,a post fall investigation, the Lippincott Manual of Nursing Practice, and Mosby's Long Term Care Assistants, it was determined the facility failed to follow the comprehensive care plan for two (2) of twenty-two (22) sampled residents (Residents #6 and #8). The facility failed to ensure the indwelling catheter was anchored for stabilization to prevent complications of skin breakdown for Resident #8. The facility failed to ensure contracture devices were applied to Resident #6's hands. The findings include: Review of the facility's policy for, Comprehensive Plan of Care, dated 08/31/12, revealed the care plan identified resident-centered interventions to address the means for how the resident would meet their goals. However, it did not address potential complications from the use of an indwelling catheter and lack of anchoring the tubing to prevent the resident from developing pressure areas. Review of the facility's policy regarding Indwelling Catheters, dated 08/31/12, revealed care and treatment would be provided to reduce catheter associated complications. The policy further stated under Conditions which may occur related to complications from catheter use listed Urinary Tract Infection; Bacteremia; Febrile episodes; Bladder stones; Fistula formation; Erosion of the urethra; Epididymitis; Chronic renal inflammation; [MEDICAL CONDITION]; and, Blocked catheters. However, the policy did not specify potential complications from lack of anchoring the tubing to prevent the resident from laying on the tubing and developing pressure areas. Review of the Lippincott Manual of Nursing Practice, 10th Edition, 2014, Section Pressure Ulcers, page 183, revealed pressure applied for longer than 2 hours could produce tissue destruction; healing cannot occur without relieving the pressure. Section Catheterization, page 781, revealed properly anchoring the catheter prevented catheter movement and traction on the urethra; keeping the tubing over the patient's leg helped prevent kinking or forming loops of stagnant urine; and, maintaining unobstructed urine flow to prevent reflux of contaminated urine into the bladder or pooling of urine in the loops of the tubing. Review of the Mosby, 4th Edition, Long Term Care Assistants, 2003, page 363, Section Care for Persons with Indwelling Catheters, revealed urine should be allowed to flow freely through the catheter tubing, should not have kinks and the person should not lie on the tubing. The catheter should be anchored to the inner thigh to prevent excessive catheter movement and friction. 1. Review of Resident #8's clinical record revealed the facility readmitted the resident on 12/11/14, with [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly MDS assessment, completed on 05/07/15, revealed the facility assessed the resident during

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F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 06/25/13, with goal revisions on 02/18/15 and the target date for 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, [MEDICAL CONDITION] (swelling), and an indwelling catheter. Interventions listed on the care plan included ensuring the catheter tubing was positioned properly. However, the care plan did not address potential complications related to not anchoring the tubing. In addition, the care plan included the resident was at risk for complications associated with [MEDICAL CONDITION], imitated on 06/25/13, and goal target date was 08/27/15. Intervention included monitor for signs and symptoms of injury, infection or ulcers. Observation, on 06/14/15 at 3:20 PM and, on 06/16/15 at 2:20 PM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 10:40 AM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 2:45 PM, during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP) revealed Resident #8 had a new area of skin pressure measuring 9.5 cm X 2.5 cm X 0.1 cm. deep, the skin was pink and shiny with the top layer of the blister missing on his/her left posterior thigh. The bedside drainage bag was hanging on the left side of the resident's left side of the bed and the indwelling catheter tubing was not anchored. Interview with the ARNP, on 06/17/15 at 2:45 PM, revealed the area was the size and shape of the catheter tubing and connector where it laid under the thigh and caused a blister and skin breakdown. The ARNP stated the resident's indwelling catheter tubing should be anchored to prevent trauma, thus ensuring the resident did not lay on the tubing, failure to do so caused the blister to occur. Interview with Resident #8, on 06/17/15 at 3:05 PM, revealed the indwelling catheter tubing was anchored at times and other times was not anchored. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM and LPN #6 on 06/17/15 at 3:15 PM, revealed Resident #8's catheter tubing should not be under the resident's extremities. The tubing was supposed to be anchored to keep the tubing out from under the resident. Per LPN #7, anchoring the tubing prevented the resident from laying on the tubing. Interview with Certified Nurse Aide (CNA) #2, on 06/17/15 at 3:30 PM, revealed indwelling catheter tubing was supposed to be secured with an anchor type system so the tubing did not get under the resident's legs. She stated the catheter tubing could cause blisters and skin sores. Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy included the indwelling catheter tubing should be anchored to maintain positioning to keep the tubing from under the resident, per the resident's plan of care. 2. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 09/02/14 with [DIAGNOSES REDACTED]. Review of Resident #6's Minimum Data Set (MDS) quarterly assessment, dated 03/26/15, revealed the resident had been diagnosed with [REDACTED]. In addition, the resident needed extensive assistance with dressing, toilet use, personal hygiene and bathing. Review of Resident #6's clinical record (care plan), revealed one of the goals was to be free from complications of [MEDICAL CONDITIONS] including Contractures, [MEDICAL CONDITION], Aspiration Pneumonia, and Dehydration, with a target date of 07/23/15. Restorative Nursing Services was listed as an intervention toward achieving that goal. Review of Resident #6's care plan for Daily Care Needs, related to his/her history of a [MEDICAL CONDITION], revealed the care plan was initiated on 10/14/14 and listed restorative nursing services. In addition, staff were to monitor for any declines and/or contractures and to refer the resident back to therapy, as needed. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record/Restorative Care Plan for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Review of the Certified Nursing Assistant (CNA) Assignment Sheet, titled Twin Spires East, dated 06/14/15, did not reveal any information about Resident #6's left-hand palm guard, his/her elbow extension, or the soft carrot for placement in the resident's right hand. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Observation, on 06/14/15 at 6:20 PM, revealed Resident #6 did not have his/her hand splint, elbow device, or soft carrot in place. Observation, on 06/15/15 at 10:48 AM, revealed the soft carrot device was on the resident's bedside table, not in the resident's right hand. Observation, on 06/15/15 at 3:30 PM, revealed Resident #14's hands were in a closed position, and he/she did not have a palm guard on his/her left hand nor a carrot device in his/her right hand. Observation, on 06/16/15 at 8:50 AM, revealed Resident #6's hands were exposed and the palm guard and the soft carrot had not been applied to his/her hands. The soft carrot was observed on the bedside table next to the resident's bed. Observation, 06/16/15 at 10:30 AM, of the skin assessment and wound care for Resident #6, revealed the resident did not have the soft carrot in his/her right hand or the left hand palm guard in place at the beginning or during any portion of the skin assessment and wound care provided by the resident's nurse. Interview, on 06/17/15 at 10:20 AM with Licensed Practical Nurse (LPN) #1, revealed she thought restorative CNAs were to perform restorative care for Resident #6, but stated she was not sure when restorative care was provided for the resident. LPN #1 stated she thought Resident #6 sometimes tossed the carrot away after it was placed as she had seen the carrot in the resident's hand but had also found it in the resident's bed while providing care. Interview, on 06/17/15 at 2:20 PM, with the Restorative CNA (RCNA) #1, revealed she provided restorative nursing care to Resident #6 about three (3) weeks ago, but was not currently assigned to provide restorative nursing care for the resident. The RCNA stated Resident #6 tolerated the devices with no difficulty during the time she was assigned to place the palm guard and carrot. The RCNA stated the resident had previously kept the carrot in his/her hand about three (3) hours at a time. Interview, on 06/17/15 at 2:30 PM with CNA #2, revealed she had been assigned to care for Resident #6, but had not been told to place the carrot or the palm guard, and had never applied any splint/palm guard devices to Resident #6's hands or arms. Interview, on 06/17/15 at 4:00 PM with the Director of Nursing (DON), revealed Resident #6 did have contractures and had been assessed for placement/use of anti-contracture devices. The DON stated the resident's history of contractures and restorative nursing was mentioned in the Activity of Daily Living (ADL)/Daily Care Needs component of the resident's care plan. Resident #6's devices should have been applied.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to transcribe orders written by the physician for Physical Therapy for one (1) of twenty-two (22) sampled residents (Resident #2). As a result, Resident #2 did not receive Physical Therapy services as ordered by the physician. The findings include: Interview with the Director of Nursing (DON), on 06/17/15 at 3:15 PM, revealed there was no policy addressing the transcription of physician orders [REDACTED].#2. Review of the clinical record for Resident #2, revealed the facility admitted Resident #2 with [DIAGNOSES REDACTED]. Review of Resident #2's Annual Minimum Data Set (MDS) assessment, completed by the facility on 05/15/15, revealed the facility assessed the resident as requiring total assistance from staff for bed mobility, dressing, and toileting care. Resident #2 also required extensive assistance to complete personal hygiene and required a two (2) person staff assist to

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) transfer with the use of a Hoyer lift. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment on 05/15/15 and scored the resident as a fourteen (14) out of fifteen (15) meaning the resident was interviewable. Review of the physician's orders [REDACTED]. Review of the Nurses' Notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse received a physician's orders [REDACTED]. Review of the nurses' notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse received a physician's orders [REDACTED]. Interview with Resident #2, on 06/15/15 at 1:30 PM, revealed Physical Therapy assisted the resident in the past to get out of bed and into a wheelchair. However, the resident stated that he/she had gotten sick, been admitted to the hospital, and his/her pressure wound had gotten worse. Then the physician had placed Resident #2 on complete bed rest. Resident #2 stated the complete bed rest had made his/her muscles weak and felt he/she could no longer sit up or hold up his/her head. Resident #2 stated he/she felt stuck in the bed in the room all of the time. Resident #2 stated he/she would like to get out of the bed and felt his/her quality of life would improve by getting out of the bed. Resident #2 stated he/she was unaware the physician had placed an order on 06/10/15 for Physical Therapy to assist the resident to get into a wheelchair twice per day for an hour at a time. The resident stated this had not happened. Interview with CNA #4, on 06/16/15 at 5:10 PM, revealed the CNA provided care for Resident #2. She stated Physical Therapy used to assist Resident #2 to get into a wheelchair; however, the resident's wounds became worse and the resident's physician placed him/her on bed rest. Interview with Licensed Practical Nurse (LPN) #4, on 06/17/15 at 9:05 AM, revealed the process by which nursing documented and communicated physician's orders [REDACTED]. She revealed a nurse would take an order off when it was written by a physician. The nurse would then place a copy of the order into a binder for review by members of the Interdisciplinary Team to discuss in morning meeting. She stated she did not recall an order coming in for Physical Therapy for Resident #2 on 06/10/15. She stated the facility admitted Resident #2 with a large sacral pressure wound. She stated the wound was nearly healed when the resident became ill and went to the hospital for treatment. The resident returned to the facility and the wound was much worse. The Physician placed Resident #2 on bed rest at that time and the wound was healing and looking better. LPN #4 stated prior to hospitalization , Resident #2 had been receiving Physical Therapy to sit up in a wheelchair. At that time, Resident #2 could only sit up for a short time due to dizziness and pain. Interview with the Physical Therapist, on 06/17/15 at 9:40 AM, revealed the therapy department was unaware of the physician order [REDACTED].#2. She stated Resident #2 had previously received Physical Therapy and the resident had been discharged . The Physical Therapist stated she did not receive a referral or information from the nursing staff that the physician had written a new Physical Therapy order for Resident #2. The Physical Therapist further stated the purpose of Physical Therapy was to restore functioning and maximize functioning potential. She stated Resident #2 would miss opportunities to get out of bed and work on restoring functioning. Interview with the Unit Manager of the Mint Julep Hall, on 06/17/15 at 1:40 PM, revealed the process by which the nursing staff would take off new medical orders and communicate the orders to the facility was either she or another nurse would take a physician's orders [REDACTED]. The nurse would place a copy of the order in a binder. Medical Records retrieved the binders, copied the information, and disseminated the information to the members of the Interdisciplinary Team. The Interdisciplinary Team met each morning in morning meeting to discuss the new orders, update care plans, and communicate new information about residents. The Unit Manager reviewed the process on 06/10/15 and revealed the nurse who took the order for Resident #2's Physical Therapy documented the information in the nurses' notes per the new protocol. Interview with Medical Records, on 06/17/15 at 2:06 PM, revealed Medical Records had retrieved and distributed the orders from 06/10/15, including the orders for Resident #2. Interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed the process for communicating physician's orders [REDACTED]. The MDS Coordinator stated a member of the Interdisciplinary Team, usually the Director of Nursing (DON), social worker, or another member would read the orders and information from the 24-hour report. She would review and update care plans as appropriate per the information from physician's orders [REDACTED]. She stated she did not update the care plan for Resident #2 after the physician ordered Physical Therapy on 06/10/15. She stated she would have updated the care plan for Resident #2 when the Interdisciplinary Team read those orders because Resident #2 was not receiving Physical Therapy at that time. She further stated she received a copy of the physician orders [REDACTED]. However, the MDS Coordinator stated she did not go through the physician's orders [REDACTED]. Interview with the DON, on 06/17/15 at 3:15 PM, revealed the process of communicating orders and new treatments failed for Resident #2. The DON stated several issues contributed to the breakdown of the system on the morning meeting after nursing received the order on 06/10/15 for Resident #2 to receive Physical Therapy. The DON stated the Unit Manager was on vacation, the DON had to leave the interdisciplinary meeting part of the way through due to other issues, and other interruptions occurred during the meeting that day. The DON stated this was a new system and the facility continued to work the bugs out of the new system to communicate changes and updates. The DON stated the order was either not read during the morning meeting, or distractions occurred which caused everyone in the meeting to miss the order being read. The DON stated the incident put Resident #2 at increased risk for potential decline in overall health and condition.
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure contracture devices were applied for one (1) of twenty-two (22) sampled residents (Resident #6). The findings include: Review of the clinical record for Resident #6, revealed the facility admitted the resident on 09/02/14 with [DIAGNOSES REDACTED]. Review of Resident #6's MDS quarterly assessment, dated 03/26/15, revealed [DIAGNOSES REDACTED]. The facility assessed Resident #6 as needing extensive assistance with dressing, toilet use, personal hygiene, and bathing. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Review of Resident #6's care plan revealed he/she had a goal to be free from complications of a [MEDICAL CONDITIONS] including Contractures, [MEDICAL CONDITION], Aspiration Pneumonia, and Dehydration, with a target date of 07/23/15. Restorative Nursing Services was listed as an intervention toward achieving that goal. Review of the Functional Assessment, dated 04/07/15, completed by Restorative Nursing, revealed a goal for Resident #6 to tolerate a left hand palm guard, a right upper extremity soft elbow extension splint, and a carrot to his/her right hand that was contracted. The resident's care planned goal was to tolerate application of the left- hand palm guard, soft elbow extension and carrot every day, five-six (5-6) times per week. Review of the Certified Nursing Assistant (CNA) Assignment Sheet, titled Twin Spires East, dated 06/14/15, did not reveal any information about Resident #6's left hand palm guard, his/her elbow extension, or the soft carrot for placement in the resident's right hand. Review of the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Observation, on 06/14/15 at 6:20 PM, revealed Resident #6 was in bed, awake and awaiting his/her supper meal. The resident was positioned on his/her right side, on a low air loss mattress. The resident did not have his/her hand splint, elbow device, or soft carrot in place. Observation, on 06/15/15 at 10:48 AM, revealed Resident #6 was seated in a Geri-Chair in his/her room. The soft carrot device was observed on the resident's bedside table, and not placed in the resident's right hand.

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	185196	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Observation, on 06/15/15 at 3:30 PM, revealed Resident #6 was awake, in bed and his/her hands were visible. Resident #6's hands were in a closed position, and he/she did not have the hand splint or carrot device in either hand. During the observation, it was noted the resident had a reddened/purple colored area on the palm of his/her right hand, just below the base of the thumb, that was visible even though his/her hand was in a closed position. Observation, on 06/16/15 at 8:50 AM, revealed Resident #6 was awake, in bed and had just finished his/her breakfast. Resident #6's hands were exposed and the palm guard and the soft carrot had not been applied to his/her hands. The soft carrot was observed on the bedside table next to the resident's bed. Observation, 06/16/15 at 10:30 AM, of the skin assessment and wound care for Resident #6, revealed he/she continued to have a reddened/purple colored area on the palm of his/her right hand, just below the base of the thumb. The resident did not have the soft carrot in his/her right hand or the left hand palm guard in place at the beginning or during any portion of the skin assessment/wound care observation. Interview, on 06/16/15 at 10:40 AM, with Licensed Practical Nurse (LPN) #1, during the skin assessment revealed the site at the resident's right hand was new to him/her, and that she measured it to be 2.3 by 1.4 centimeters. LPN #1 stated she thought the area looked dark red, and it could be a blister or hematoma. LPN #1 stated she would call the Advanced Registered Nurse Practitioner (ARNP), wound care nurse, to report the area and obtain any orders for treatment. Further interview, on 06/17/15 at 10:20 AM with LPN #1 revealed she thought restorative CNAs were to perform restorative care for Resident #6, but stated she was not sure when restorative care was provided for the resident. LPN #1 stated at times Resident #6 would toss the carrot away after it was placed. She had seen the carrot in the resident's hand, but had also found it in the resident's bed while providing care. Interview, on 06/17/15 at 2:20 PM, with the Restorative CNA (RCNA) #1 revealed she provided restorative nursing care to Resident #6 about three (3) weeks ago, but was not currently assigned to provide restorative services to the resident. The RCNA stated Resident #6 tolerated the devices with no difficulty during the time she was assigned to place the palm guard and carrot. The RCNA stated the resident had previously kept the carrot in his/her hand about three (3) hours at a time. Interview, on 06/17/15 at 2:30 PM, with CNA #2 revealed she had been assigned to care for Resident #6, but had not been told to place the carrot or the palm guard, and had never applied any splint/palm guard devices to Resident #6's hands or arms. CNA #2 stated she had cleaned Resident #6's hands with a wash cloth by wrapping the cloth around her own finger to clean inside the resident's palms, but had not noticed any redness or irritation on the resident's right hand. Observation, on 06/17/15 at 1:35 PM, revealed the ARNP for the facility's wound care services visited/assessed the area on Resident #6's right hand. Interview, on 06/17/15 at 1:40 PM, with the ARNP for wound care services revealed she observed the area on Resident #6's right hand and thought the area was fluctuant and should be monitored for size and change at this time. The ARNP stated the resident should not have the carrot placed in the hand until the area reabsorbs. Interview, on 06/17/15 at 4:00 PM, with the Director of Nursing (DON) revealed she had a conversation with Resident #6's daughter and the resident's daughter thought the resident chewed on his/her right hand and this may have caused the area. The DON stated Resident #6 had a behavior of chewing his/her [MEDICAL CONDITION] plug, picking his/her nose and playing with his/her [MEDICAL CONDITION] bag, but stated she had no previous awareness that Resident #6 chewed his/her hand. The DON stated Resident #6 had contractures of both hands and anti-contracture devices that were ordered and assessed, should be in use/applied. However, the DON stated the Wound Care ARNP assessed Resident #6's hand today (06/17/15) and recommended the carrot not be placed until the area on the resident's right hand reabsorbed.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review, review of the Lippincott Manual of Nursing Practice, and Mosby's Long Term Care Assistants, it was determined the facility failed to ensure residents at risk for pressure ulcers received the necessary treatment and services to prevent the development of new pressure ulcers for one (1) of twenty-two (22) sampled residents (Resident #8). The facility assessed Resident #8 with an avoidable pressure ulcer, on 06/17/15, related to the indwelling catheter was not stabilized by anchoring the tubing to reduce the complicatons of skin breakdown. The resident's thigh laid on the tubing and connector and developed a blistered area that sloughed the top layer of skin and progressed to a pressure area. The findings include: The facility did not provide a policy regarding pressure areas. Review of the Lippincott Manual of Nursing Practice, 10th Edition, 2014, Section Pressure Ulcers, page 183, revealed pressure applied for longer than 2 hours could produce tissue distruction; healing cannot occur without relieving the pressure. Section Catheterization, page 781, revealed properly securing the catheter prevented catheter movement and traction on the urethra; keeping the tubing over the patient's leg helps prevent kinking or forming loops of stagnent urine; and, maintaining unobstructed urine flow to prevent reflux of contaminated urine into the bladder or pooling of urine in the loops of tubing. Review of the Mosby, 4th Edition, Long Term Care Assistants, 2003, page 363, Section Care for Persons with Indwelling Catheters, revealed urine should be allowed to flow freely through the catheter tubing, should not have kinks and the person should not lie on the tubing. Secure the catheter to the inner thigh to prevent excess catheter movement and friction. Review of Resident #8's clinical record revealed the facility readmitted the resident on 12/11/14, with [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 05/07/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as a fifteen (15) of fifteen (15) and meaning the resident was interviewable. Review of the Comprehensive Care Plan, dated 06/25/13, for Resident #8 revealed goal revisions on 02/18/15 and the target date for 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, [MEDICAL CONDITION] (swelling), and an indwelling catheter. Interventions listed on the care plan included ensuring the catheter tubing was positioned properly. In addition, the care plan included the resident was at risk for complications associated with [MEDICAL CONDITION], initiated on 06/25/13, and a goal target date of 08/27/15. Interventions included to monitor for signs and symptoms of injury, infection or ulcers. Observations of Resident #8 during the initial tour, on 06/14/15 at 3:20 PM, revealed a bedside drainage bag in a dignity bag for an indwelling catheter was placed on the resident's left side of the bed. Observation, on 06/16/15 at 2:20 PM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 10:40 AM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 2:45 PM, revealed during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP), Resident #8 requested the ARNP to assess his/her left posterior thigh. A new area was identified that measured 9.5 cm X 2.5 cm X 0.1 cm. deep, the skin was pink and shiny with the top layer of the blister missing. Observation at the time of the skin assessment revealed the resident's indwelling catheter tubing was not anchored to prevent the resident from laying ontop of it. Interview with ARNP, on 06/17/15 at 2:45 PM, revealed Resident #8 had [MEDICAL CONDITION] and Arterial Disease, which was the worst of both worlds. She stated the Arterial Disease lead to the swelling, plus the [MEDICAL CONDITION] lead to the wounds on posterior thigh. She stated the areas on Resident #8's right lower extremity was unavoidable and now healed; however, the area on his/her left posterior thigh was new. She stated the area was the size and shape of the catheter tubing and connector where he/she had it under the thigh and caused a blister and skin breakdown. However, she did not stage the area. The ARNP stated the area on the left thigh was avoidable, by keeping the resident's indwelling catheter tubing position secured and not under the resident. Review of the weekly skin assessment dated [DATE] revealed there were no new areas identified. Interview with Certified Nurse Aide (CNA) #2, on 06/17/15 at 3:30 PM, revealed indwelling catheter tubing was suppose to be

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) secured with an anchor type system so the tubing did not get under the residents legs. She stated the catheter tubing could cause blisters and skin sores. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM, revealed he was not aware of the area of skin breakdown on Resident #8's thigh until it was identified with the ARNP. He stated the catheter tubing should not be under the resident's extremities. The tubing was suppose to be anchored to keep the tubing out from under the resident. Anchored tubing prevented the resident from laying on the tubing. Interview with LPN #6, on 06/17/15 at 3:15 PM, stated indwelling catheter tubing should be anchored to secure the tubing and the position of the tubing. Interview with Resident #8, on 06/17/15 at 3:05 PM, stated the indwelling catheter tubing was anchored at times and other times was not anchored. Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy included the indwelling catheter tubing should be anchored to maintain positioning to keep the tubing from under the resident. She stated the ARNP gave the facility a new order to anchor the catheter with paper tape. She reported tape was also a method to secure the indwelling catheter tubing. She stated a resident laying on the catheter tubing had the potential of blistering of the skin and skin breakdown. She reported the resident's break in the skin integrity could have been prevented by the catheter tubing not being left under the resident leg.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record and policy review, it was determined the facility failed to ensure three (3) of twenty-two (22) sampled residents (Residents #4, #7, and #15) with indwelling urinary catheters, received appropriate care and treatment associated with management of indwelling urinary catheters. The indwelling catheters for Resident's #4, #7, and #15, were not anchored to prevent dislodgement, trauma and/or infection. The findings include: Review, of the facility's policy titled Indwelling Catheters, dated 08/31/12, revealed several guidelines for the care and treatment for [REDACTED]. Among those guidelines, catheter tubing was to be secured using an anchoring device to prevent movement and urethral traction. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 06/10/13, with the [DIAGNOSES REDACTED]. Review of Resident #4's Quarterly MDS assessment, completed on 05/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as eleven (11) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a care plan on 03/31/15, with goal revisions on 05/20/15 and the target date of 08/27/15, for an indwelling catheter. Interventions listed included ensuring the catheter tubing was positioned properly; observe urine for changes in characteristics, foul odor, and pain; and, provide catheter care every shift. Observation, on 06/17/15 at 3:40 PM, with Certified Nursing Assistant (CNA) #3 present, revealed Resident #4's indwelling catheter bedside drainage bag was placed in a dignity bag hanging on the left side of the resident's bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying loose on top of the resident's left thigh, no skin breakdown was noted. Interview with CNA#3, on 06/17/15 at 3:40 PM, revealed indwelling catheter tubing was supposed to be anchored to the resident's leg to prevent the catheter tubing from moving. Interview with Resident #4, on 06/17/15 at 3:40 PM, revealed the indwelling catheter tubing had been anchored to his/her leg with tape at times. 2. Review of Resident #15's clinical record revealed the facility admitted the resident on 10/08/14, with the [DIAGNOSES REDACTED]. Review of Resident #15's Quarterly MDS assessment, completed on 04/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #15 revealed the facility developed a care plan on 10/28/14, with a target date of 07/23/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe for urinary tract infection; monitor intake and output; and, monitor for pain and discomfort. Observation, on 06/17/15 at 3:45 PM, with Registered Nurse (RN) #1 present, revealed Resident #15's indwelling catheter drainage bag was in a dignity bag hanging on the left side of the resident's bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying loose on top of the resident's left thigh, no skin breakdown noted. Interview with RN #1, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to the resident's leg to keep the catheter tubing in place and to keep the resident from laying on the tubing. Interview with Resident #15, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to his/her leg with tape. 3. Review of Resident #7's clinical record revealed the facility admitted the resident on 08/22/14, with [DIAGNOSES REDACTED]. Review of Resident #7's Quarterly MDS assessment, completed on 05/11/2015, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as (2) two of (15) fifteen, which meant the resident was not interviewable. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 08/26/14. Problems on the care plan included the resident was at risk for falls related to increased fall risk score, poor cognition, poor safety awareness and past attempts to get out of bed unassisted. In addition, the care plan included the resident was at risk for skin breakdown related to current pressure area, decreased mobility and history of decreased nutritional intake. The care plan also stated that Resident #7 could not meet his/her own daily care needs without assistance from staff. The care plan also had an intervention of an indwelling catheter to bedside drainage. Observation, on 06/16/15 at 3:20 PM, revealed Resident #7 was laying in the bed with a drainage bag placed on the resident's left side of the bed. Observation of a skin assessment, on 06/15/15 at 1:50 PM, with LPN #6, revealed no new skin areas related to the indwelling catheter. Continued Interview with the Director of Nursing, on 06/17/15 at 4:15 PM, revealed the facility practice was to anchor indwelling catheter tubing to the resident leg with an anchoring device, unless the physician orders [REDACTED]. She stated the anchoring of the indwelling catheter ensures the tubing does not get under the residents legs, mispositioned or tugged on. The facility practice is to use an anchoring device on each resident with a catheter. She stated it was the facility policy was to anchor the indwelling catheter; however, that was not the case during this time.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, it was determined the facility failed to consistently implement and follow their infection control practices for two (2) of twenty-two (22) sampled residents (Residents #11 and #14). The facility failed to ensure Nursing, Housekeeping and Rehabilitative staff consistently used personal protective equipment (PPE), isolation protocol and environmental disinfection. The findings include: Review of the facility's policy regarding Clostridium Difficile Infection-Associated Diarrhea, dated 06/01/15, revealed known or suspected Clostridium Difficile (C-Diff or [DIAGNOSES REDACTED]) infection, in any resident, indicated

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) implementation of isolation PPE, altered hand hygiene to include washing of hands with soap and water and implementation of specialized environmental disinfectant agents and practices. Due to the degree to which the environment becomes contaminated with spores of [DIAGNOSES REDACTED] and the potential for soiling and contamination of clothing and hands, put on a gown and gloves before entering the resident's room when caring for the resident. Wash hands with soap and water. 1. Review of Resident #11's clinical record revealed the facility admitted him/her on 10/31/14 with [DIAGNOSES REDACTED]. Further review of the clinical record revealed Resident #11 had chronic[DIAGNOSES REDACTED] and the facility placed the resident in Contact Isolation on 01/06/15. Review of Resident #11's Quarterly Minimum Data Set (MDS) assessment, completed by the facility on 03/13/15, revealed a Brief Interview for Mental Status (BIMS) score was a (15) fifteen of fifteen (15) meaning the resident was interviewable. Review of the Comprehensive Care Plan, dated 12/10/14, for Resident #11, revealed he/she was non-ambulatory and at risk for falls, incontinent of bowel and bladder and at risk for for skin breakdown. Observations, on 06/14/15 at 6:35 PM, of Resident #11's room revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. A yellow PPE gown was draped over the bottom of Resident #11's bed. Discarded PPE was observed in an uncovered bedside trash can. The privacy curtain pooled into the trash can co-mingling with used and discarded PPE. Observation, on 06/14/15 at 6:41 PM, revealed the dinner meal cart arrived to the East Hall and was placed outside of room [ROOM NUMBER], identified as an isolation room. The door to room [ROOM NUMBER] had a door hanging container for Personal Protective Equipment (PPE) hung on the door on the hall side of door. The door to room [ROOM NUMBER] was open to corridor with staff were present. The food cart door was opened and released to swing back into the isolation room and rested against the open isolation room door. Observation, on 06/14/15 at 6:50 PM, revealed room [ROOM NUMBER]'s door was open to the corridor. A door hanging container for Personal Protective Equipment (PPE) was hung on the door. A garbage can without a lid was located just inside the door. The open garbage can contained PPE (yellow gown and gloves) with the resident's privacy curtain inside the garbage can touching the PPE. Interview with Licensed Practical Nurse (LPN) #6, on 06/14/15 at 6:51 PM, revealed the meal tray cart door open to the inside of an isolation room had the potential for cross contamination with other residents and the spread of the infection. Observation, on 06/14/15 at 6:45 PM, revealed CNA #11 entered the room walking past Resident #11's bed to deliver a meal tray to bed 2 without donning PPE. Observation, on 06/14/15 at 6:45 PM, revealed Resident #11's visitor entered the room and donned the PPE gown from the foot of bed, but the resident's visitor did not don gloves. Interview with Resident #11's visitor, on 06/17/15 at 2:00 PM, revealed Resident #11's visitor had been educated regarding the importance of PPE, but stated it was too hot to wear the gear as recommended. Observations, on 06/14/15 at 6:45 PM, revealed CNAs #5, #12 and #13 stopped with the meal cart in front of Resident #11's opened door. When they opened the meal cart, the cart door fully swung into Resident #11's room and rested against the PPE caddy on the door. When CNA #12 began to close the meal cart door, LPN #6 came and wiped down the cart door with a bleach wipe after surveyor intervention. Interview, on 06/15/15 at 3:10 PM, with LPN #6 revealed she had been educated on Infection Control on 6/14/15, 6/15/15, annually and during her original orientation. Interview, on 06/17/15 at 10:40 AM, with CNA #5 revealed that he/she had worked for the facility for one (1) year and had received training multiple times over the course of that year via video and 1:1 education. Observations, on 06/15/15 at 9:45 AM, revealed Housekeeper #1 was cleaning Resident #11's room without PPE. She was observed placing the trash can full of soiled and discarded PPE into her cart trash. She did not use any one-time cleaning tools and she did not head toward the housekeeping cart room to change out the mophead or broom. Housekeeper #1 began down the hallway, in the opposite direction of the cartroom, to clean the next room when interrupted by the Housekeeping Manager who explained to her that room [ROOM NUMBER] was an isolation room and would need to be recleaned with alcohol. The Housekeeping Manager then walked with Housekeeper #1 toward the housekeeping cart room. The Housekeeping Manager further explained that room [ROOM NUMBER] would need to be recleaned with alcohol. Observation of Resident #11, on 06/15/15 at 10:40 AM, revealed the resident was in isolation and visitors were in the room without personal protective equipment. Observations, on 06/15/15 at 11:55 AM, of Resident #11's room, revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. A new trash can was in the room with a lid that could be operated by a foot pedal. However, soiled and discarded PPE were observed in the uncovered bedside trash can. The privacy curtain pooled into the trash can co-mingling with used and discarded PPE. Interview with CNA #9, on 06/15/15 at 4:42 PM, revealed Resident #11 had [DIAGNOSES REDACTED] and was on Contact Precautions. She stated the resident's visitors were supposed to be wearing gowns and gloves while in the room. Observations, on 06/16/15 at 8:50 AM, of Resident #11's room revealed soiled clothing on the bedside table in an unlined bin spilling over onto the table, which contained boxes of leftover food and open beverage containers. The foot pedal operated trash can with a lid was now lined with a red biohazard liner. However, soiled and discarded PPE were observed in the uncovered bedside trash can. The privacy curtain continued pooled into the trash can co-mingling with used and discarded PPE. Observations, on 06/16/15 at 2:15 PM, revealed Speech Therapist #20 in Resident #11's room working with his/her roommate without donning PPE. Interview, on 06/17/15 at 1:45 PM, revealed the Speech Therapist entered Resident #11's room on 06/16/15 to work with his/her roommate without donning PPE. She stated that she worked at multiple facilities and the infection protocol differed with each one. She couldn't remember the specifics for this facility, and when she saw the yellow PPE caddy, she chose to ignore it. Interview with the Housekeeper, on 06/17/15 at 9:50 AM, revealed she was unaware that Resident #11 had an infection. She didn't have any work experience in healthcare housekeeping and did not know what the yellow PPE caddies on the doors meant. She stated she had not been trained to clean rooms using the infection control protocol, but she now understood she should be cleaning with alcohol in those rooms. Interview with the Housekeeping Manager, on 06/17/15 at 10:00 AM, revealed he had retrained all housekeeping staff on the infection protocol and environmental disinfection. He believed the housekeeper was aware she should use a 10:1 bleach mixture to clean Resident #11's room and that alcohol would be ineffective. Observations, on 06/17/15 at 10:10 AM, of the Housekeeper and the Housekeeping Manager revealed the Housekeeper was unaware alcohol was an ineffective disinfection agent for Resident #11's room. When the Housekeeping Manager attempted to show her the appropriate cleaning mixture, 10:1 bleach, it was observed to be missing from her cart. 2. Review of the clinical record for Resident #14 revealed the facility admitted him/her on 11/05/12, and then readmitted the resident on 11/21/13 with [DIAGNOSES REDACTED]. The facility transferred Resident #14 to the hospital on [DATE] for evaluation, and the resident was diagnosed with [REDACTED]. Resident #14 was discharged from the hospital on [DATE] and transferred back to the facility with orders for intravenous (IV) antibiotic therapy for five (5) days. Upon Resident #14's return, the facility placed the resident under contact isolation precautions. Observation, on 06/15/15 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #2 donned a disposable gown and gloves, and went into Resident #14's room to take the resident's blood pressure. LPN #2 returned the blood pressure cuff to the hanging storage for isolation equipment on the resident's door, removed her disposable gown and gloves and placed them in a regular trash can in the room, but did not wash or sanitize her hands before exiting the room. Instead, LPN #2 stated she was going to go wash her hands, and walked down the hall and entered the public restroom in the main lobby area of the facility. Observation, on 06/15/15 at 9:50 AM, during a morning medication pass, revealed a visitor (Family #1) entered Resident #14's room, but did not don a disposable gown or gloves. Family #1 went to Resident #14's bedside and put down a plastic grocery bag. After speaking to the resident, Family Member #1 moved over to the empty bed belonging to the other occupant in the room, laid what looked like some photos/papers on that occupant's bed and used his/her phone to take a picture of the photos/papers. Family #1 then returned to Resident #14's side of the room with the phone/camera and the photos/pieces of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185196	A. BUILDING _____ B. WING _____	**06/17/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED NURSING AND REHABILITATION-BASHFORD	**3535 BARDSTOWN ROAD LOUISVILLE, KY 40218**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) paper. Shortly thereafter, Family #1 exited Resident #14's room, obtained a tape dispenser from the 100 hallway nurses' station, and carried it into Resident #14's room. Again, Family #1 entered Resident #14's room without donning a disposable gown and gloves. After using the tape, Family #1 left Resident #14's room and returned the tape dispenser to the 100 hallway nurses' station. LPN #2 was preparing medication for Resident #14 at the medication cart just outside the resident's room while Family #1 was entering and exiting the room, but LPN #2 did not guide Family #1 to don Personal Protective Equipment (PPE) before entering Resident #14's room. Observation, on 06/15/15 at 10:05 AM, revealed LPN #2 donned a disposable gown and gloves and entered Resident #14's room to administer the resident's medication. Upon exiting the room, LPN #2 removed the PPE and then went to the restroom just behind the 100 hall nurses' station to wash her hands. Interview, on 06/15/15 10:10 AM with LPN #2, revealed Resident #14 had ESBL in his/her urine, and was in contact isolation, but she did not like washing her hands in the bathroom in Resident #14's room because the other occupant of the room frequently urinated in that restroom, making a mess. LPN #2 stated housekeeping had to frequently clean that restroom. Interview, on 06/15/15 at 11:10 AM, with Family #1, revealed she was a sitter who stayed with Resident #14 three (3) days each week. Family Member #1 stated during a recent hospitalization , Resident #14's physician, at the hospital, told her it was not necessary to wear Personal Protective Equipment (PPE) while in the resident's hospital room. Family #1 stated since Resident #14's readmission to the long term care facility, no one on staff had told her to wear PPE while in the resident's room.