

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

PRINTED: 01/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER ALDRSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DR TOPEKA, KS 66614		
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F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157			

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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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 181 residents. The sample included 4 residents. Based upon observation, record review and interviews the facility failed to promptly notify the resident's physician in a timely manner regarding 1 (#1) resident who had loose stools and also failed to notify an interested family member when 1 (#2) resident was transferred to a local hospital.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #1's admission Minimum Data Set 3.0 dated 11/22/12 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, did not exhibit any behaviors, required extensive staff assistance with bed mobility, transfers, walking in the room, locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS included the resident utilized a walker and a wheelchair and was continent of bowel and bladder. <p>The resident's care plan dated 11/30/12 and revised on 12/3/12 and 12/20/12 included the resident required extensive staff assistance of 1 for transfers and toileting. The care plan included the resident's medications included Coumadin (an anticoagulant) and staff observed the resident for signs/symptoms of diarrhea.</p> <p>Review of the resident's December 2012 medication administration record revealed the facility received a physician's order on 12/6/12 for the resident to receive 7.5 milligrams (mg) of Coumadin on Monday, Wednesday and Friday</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>and Coumadin 5 mg on Tuesday, Thursday, Saturday and Sunday (the resident received the Coumadin until 12/25/12).</p> <p>A physician's order dated 12/19/12 and not timed, read for the facility to administer 2 mg of Imodium (anti-diarrhea medication) initially (2 tabs), then 1 tablet after each loose stool not to exceed 8 tablets in 24 hours, and to telephone the resident's primary care physician if the diarrhea lasted more than 24 hours.</p> <p>A nurse's note dated 12/16/12 timed 1:47 P.M. included the resident was up to restroom two times that A.M. with slightly loose but still formed bowel movements (BM) and staff informed the resident if he/she continued to have loosely formed stools, he/she would administer Imodium.</p> <p>A nurse's note dated 12/19/12 timed 8:17 P.M. included the resident reported he/she had diarrhea, requested Imodium and staff administered the Imodium per the physician's standing order.</p> <p>A nurse's note dated 12/23/12 timed 1:41 A.M. documented the resident had diarrhea and requested Imodium.</p> <p>A nurse's note dated 12/23/12 timed 5:10 A.M. included the resident complained of diarrhea and nausea, the resident stated he/she felt like he/she was going to throw up and the Imodium was not effective. The note included the resident stated he/she had diarrhea for the last 3 nights, and staff administered Mylanta and Imodium per physician's order.</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>A nurse's note dated 12/25/12 timed 9:46 A.M. documented the resident reported he/she had several episodes of loose stools during the night, after breakfast the resident experienced nausea and vomiting, the amount of emesis was what the resident consumed for breakfast and staff administered a 25 milligram Phenergan (medication for nausea/vomiting) suppository per physician standing order.</p> <p>A nurse's note dated 12/26/12 timed 1:57 P.M. documented the physician saw the resident and reviewed the resident's laboratory results and medications. The note did not include the facility informed the physician of the resident's diarrhea/loose stools.</p> <p>A nurse's note dated 12/27/12 timed 3:34 A.M. documented staff administered Mylanta to the resident for complaints of nausea and an upset stomach. The note included the resident complained of pain radiating in his/her abdomen to his/her back. The note included the resident's loose stools had a small amount of blood.</p> <p>A nurse's note dated 12/27/12 timed 9:48 P.M. included the facility received a physician's order for Preparation H ointment 4 times daily as needed for hemorrhoid discomfort.</p> <p>A nurse's note dated 12/28/12 timed 3:29 A.M. documented the resident requested staff assistance with toileting more frequently than typical and the resident had many loose stools.</p> <p>A nurse's note dated 12/28/12 timed 2:51 P.M. documented the resident had blood in the BM and the stool was very runny and had blood in</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>his/her BM and the stool was very runny. The note included staff administered Geri-Lanta (used to treat stomach upset) after the resident vomited once during the shift.</p> <p>A nurse's note dated 12/28/12 and timed 6:56 P.M. documented staff telephoned the resident's physician regarding the resident's abdominal tenderness, rectal bleeding, blood in his/her stool, vomiting episode on the 7-3 shift, resident received Coumadin and the facility received a physician's order to transfer the resident to a local emergency room for evaluation and treatment. The facility did not notify the resident's physician of the rectal bleeding and blood in the resident's stool for 8 hours and 56 minutes.</p> <p>A nurse's note dated 12/29/12 timed 1:55 A.M. documented the hospital admitted the resident.</p> <p>A patient examination form dated and signed by the resident's physician on 12/26/12 documented the resident had deceased bowel sounds.</p> <p>A laboratory report dated 12/26/12 documented the resident's Prothrombin time was 46.1 H (high) (normal reference range 11.8-14.8) and the resident's INR (international normalized ratio) was 4.8 (normal range).</p> <p>On 12/26/12 the facility received a physician's order to not administer Coumadin on 12/26/12 and 12/27/12, administer 5 milligrams (mg) of Coumadin on 12/28/12, 12/29/12 and 12/30/12, and to recheck the laboratory values on 12/31/12.</p> <p>The resident's history and physical (H&P) dated 12/29/12 included the resident's chief complaint</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>included lower abdominal pain with diarrhea 4 to 5 times a day for the past 4 days. The H&P documented the resident could ambulate a short distance with a walker about a week ago, and was unable to do so in the past 4 days because of the diarrhea. The H&P included a finger exam revealed the resident had pinkish liquid stool which was thought to be a diverticular bleed. The H&P documented the resident's admission diagnosis was lower abdominal pain with diarrhea 4 times a day and pinkish stool on examining finger indicating a diverticulitis bleed with an INR of 3.6 certainly could contribute.</p> <p>A stool culture report dated 1/4/13 documented the resident's stool tested positive for Clostridium Difficile Toxin B (a toxin produced by the bacteria Clostridium difficile that is very potent and lethal)</p> <p>A colonoscopy report dated 1/4/13 included the resident had active disease throughout his/her colon which was probably clostridium Difficile colitis.</p> <p>A final stool culture dated 1/7/13 included the resident's stool tested positive for Campylobacter (bacterium).</p> <p>On 1/9/13 at approximately 4:00 P.M. the resident sat in a wheelchair at a local hospital.</p> <p>During an interview with administrative nursing staff C on 1/8/13 at approximately 4:15 P.M. staff stated it was his/her understanding the hospital admitted the resident with C-Diff.</p> <p>Administrative nursing staff B on 1/8/13 at approximately 7:30 A.M. stated he/she spoke with</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>staff regarding the resident's loose stool and the staff stated the resident did not have continuous diarrhea and the resident stated the blood smears were due to his/her hemorrhoids.</p> <p>During interview with consultant therapy H on 1/9/12 at approximately 10:15 A.M. the consultant stated the resident experienced loose stools/diarrhea for approximately 5 to 7 days prior to 12/28/12. Consultant therapy H stated he/she had assisted the resident with toileting during the 5 to 7 days prior to 12/28/12 and noted blood smears on the toilet paper and he/she thought the nursing staff were aware of the blood smears. Consultant therapy H stated on 12/28/12 at approximately 10:00 A.M., he/she assisted the resident with toileting, the resident had diarrhea and he/she observed bright red blood in the toilet. Consultant staff H stated he/she immediately notified the licensed nurse of the bright red blood.</p> <p>On 1/9/12 at 11:45 A.M. licensed nursing staff F stated on 12/28/12 consultant therapy H informed him/her the resident stools had bright red blood. Licensed nursing staff F stated he/she observed 3 puddles of bright red blood and it was his/her intent to telephone and notify the resident's physician. Licensed nursing staff F stated during shift report, he/she realized he/she did not inform the resident's physician and the evening shift nurse was to inform the resident's physician.</p> <p>On 1/9/12 at approximately 1:50 P.M. direct care G stated the resident had loose stools and diarrhea about 1 week prior to hospitalization. Direct care staff G said the resident required staff assistance with toilet use and he/she had observed blood smears on the toilet paper and</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>licensed staff stated it was related to the resident's hemorrhoids.</p> <p>The facility failed to timely notify this resident's physician of the continued diarrhea, rectal bleeding and bleeding in the resident's bowel movement for this resident who received Coumadin.</p> <p>- Review of resident #2's admission Minimum Data Set dated 10/25/12 identified the resident scored 15 on the Brief Interview for Mental Status, required extensive staff assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene.</p> <p>A nurse's note dated 11/17/12 and timed 4:51 P.M. documented the resident's oxygen saturation rate was 94 percent (%) and the resident's temperature was 98.3 degrees Fahrenheit. The note included staff telephoned the resident's physician and received a physician's order to transfer the resident to a local emergency room for evaluation and treatment. The note documented the facility received a telephone call from the local hospital at 1:00 P.M. and informed staff the resident would return to the facility and staff transported the resident back to the facility. The note did not include what time the facility transferred the resident to the emergency room for evaluation and treatment.</p> <p>The clinical record lacked evidence the facility notified the resident's interested family member of the transfer.</p> <p>A nurse's note dated 11/19/12 and timed 2:40 A.M. documented the resident was diaphoretic,</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>the resident stated he/she did not feel well and something was wrong. The note included the resident's blood pressure was 62/35, heart rate was 118 beats per minute, oxygen saturation rate was 86%, on 2 liters of oxygen and the resident's temperature was 95.4 degrees Fahrenheit. The note included staff telephoned the resident's physician and received a physician's order to transfer the resident to a local emergency room for evaluation and treatment.</p> <p>A nurse's note dated 11/19/12 and timed 5:00 A.M. documented staff attempted to notify the resident's next of kin of the resident's transfer to the emergency room. The note included the next of kin's telephone rang twice, then a busy signal came on, staff was unable to leave a voicemail and the staff would contact the family later.</p> <p>A nurse's note dated 11/19/12 and timed 6:00 P.M. documented staff attempted to notify the resident's family member, the phone rang twice, busy signal came on, staff was unable to leave a voicemail and the staff would pass this on to the day shift to attempt to contact the resident's family.</p> <p>Review of a notification of death dated 11/19/12 documented the facility transferred the resident to a local emergency room and the resident expired at the hospital.</p> <p>Review of the resident's clinical record lacked evidence the day shift attempted to contact the resident's family regarding the resident's transfer to the hospital.</p> <p>During interview with nursing administrative staff</p>	F 157			

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F 157	Continued From page 9 B on 1/9/13 at approximately 10:00 A.M. staff confirmed the clinical record lacked evidence to support the facility contacted the resident's family member when the facility transferred the resident to the emergency room on 11/17/12 and lacked evidence the day shift attempted to contact the resident's family member regarding the resident's transfer to the emergency room on 11/19/12.	F 157			
F 441 SS=E	The facility facility to inform this resident's family member of the resident's transfers to the hospital. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441			

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F 441	<p>Continued From page 10</p> <p>direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 181 residents which resided on 7 units. Based upon observation, record review and interviews the facility failed to have an infection prevention and control program that performed surveillance and investigation to prevent the onset and the spread of infection and failed to effectively clean the room of 1 (#4) resident in isolation.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The facility identified 24 residents who resided on the Mulvane unit and of those 24 residents at least 12 residents experienced at least 1 loose stool/diarrhea since 12/15/12. <p>Record review of 3 residents that resided or had resided on the unit revealed all 3 residents experienced loose stools/diarrhea and 2 of the residents were diagnosed with facility acquired Clostridium Difficile (C-diff) (a bacteria found in the intestines).</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>Review of the facility's infection control data for December 2012 did not support the facility trended the data to determine clusters. Further review revealed there was no ongoing surveillance to identify the cause of the diarrhea and/or facility acquired C-diff.</p> <p>Review of the facility's January 2013 infection control data on 1/9/13 at approximately 9:25 A.M. for the Mulvane resident unit did not include information regarding residents identified with C-diff. Further review revealed there was no ongoing surveillance to identify the cause of the diarrhea and/or facility acquired C-diff.</p> <p>Nursing administrative staff D on 1/9/13 at approximately 9:30 A.M. stated he/she did not perform ongoing surveillance when a resident experienced diarrhea or those residents with facility acquired C-diff. Nursing administrative D stated the unit managers kept track and analyzed that data.</p> <p>Nursing administrative staff C (unit manager) on 1/9/13 at approximately 1:15 P.M. stated he/she did not perform ongoing surveillance when residents on the same unit experienced diarrhea or facility acquired C-diff.</p> <p>On 1/9/13 at 7:20 A.M. a sign on the front entrance of the facility alerted individuals the facility was experiencing gastrointestinal illness.</p> <p>For example, resident #1's nurse's note dated 12/28/12 and timed 6:56 P.M. documented staff telephoned the resident's physician regarding the resident's abdominal tenderness, rectal bleeding, blood in his/her stool, vomiting on the 7-3 shift,</p>	F 441			

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(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 441	<p>Continued From page 12</p> <p>and the facility received a physician's order to transfer the resident to a local emergency room for evaluation and treatment.</p> <p>A nurse's note dated 12/29/12 timed 1:55 A.M. documented the hospital admitted the resident.</p> <p>A stool culture report dated 1/4/13 documented the resident's stool tested positive for Clostridium Difficile Toxin B.</p> <p>A final stool culture dated 1/7/13 included the resident's stool tested positive for Campylobacter jejuni(bacteria infection).</p> <p>Review of resident's #4's nurse's note dated 1/2/13 and timed 3:18 P.M. documented the facility obtained a physician's order to obtain a stool culture from the resident to test for Clostridium Difficile, (C-diff) (a bacteria found in the intestines).</p> <p>A nurse's note dated 1/4/13 timed 7:46 A.M. documented per laboratory results the resident had C-diff and the facility implemented isolation precautions.</p> <p>On 1/9/13 at approximately 11:00 A.M. observation revealed a sign on the resident's door alerting visitors and staff to see the nurse before entering the resident's room and isolation gear sat outside of the resident's room. Further observation revealed the resident incontinent of bowel.</p> <p>On 1/9/13 at approximately 2:00 P.M. housekeeping staff I cleaned the resident's room with a 1:10 bleach solution. Observation revealed</p>	F 441			

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

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F 441	<p>Continued From page 13</p> <p>the resident's lunch tray (all the food consumed) sat on the resident's bedside table and housekeeping staff I did not clean the bedside table with the 1:10 parts bleach solution. During interview housekeeping staff I stated he/she normally cleaned the bedside table from top to bottom with the bleach solution but since the lunch tray sat on the table he/she did not clean the table.</p> <p>The facility provided policy for Clostridium difficile stated that C-diff can survive in the environment in its spore form for up to 6 months. Cleaning equipment used for resident with C-diff with a 1:10 dilution of sodium hypochlorite will also reduce the spread of the organism.</p> <p>The facility failed to have an infection control program that performed ongoing surveillance to determine and effectively treat residents in a prompt manner to prevent facility outbreak.</p>	F 441			