

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(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

A Standard Recertification and Abbreviated Survey was initiated on 07/23/13 and concluded on 07/25/13 with deficient practice identified at the highest scope and severity of an "G" identified at 42 CFR 483.15, Quality of Life (F-241) with the facility having an opportunity to correct before the imposition of fines. Complaint #KY00020439 was investigated and found to be unsubstantiated with no deficient practice identified.

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

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

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's residents' rights information, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of their individuality for one (1) of seventeen (17) sampled residents (Resident #3). Resident #3 stated the staff did not answer the call light in a timely manner resulting in an incontinent episode, which made him/her feel "terrible".

The findings include:

Review of the facility's "Resident Rights and Information for Residents Living in Kentucky",

F 000

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Grant Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

8/9

F 241

RECEIVED
AUG 16 2013
BY: _____

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

TITLE

(X6) DATE

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
--	--

(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 241 Continued From page 1

undated, revealed that every resident should be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.

Interview with Administrator, on 07/25/13 at 3:17 PM, revealed that facility did not have a separate dignity policy.

Review of Resident #3's medical record revealed the facility admitted the resident on 07/08/10 with diagnoses which included Gastro-Intestinal Bleed, Congestive Heart Failure, Anxiety, Type 2 Diabetes Mellitus, Pressure Ulcer Stage 2 and Urinary Tract Infection. Review of the annual Minimum Data Set (MDS) Assessment, dated 05/24/13, revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident had no cognitive impairment. Further review of the MDS revealed the facility assessed the resident as being incontinent of urine and as requiring extensive assistance with toileting.

Individual interview with Resident #3, on 07/25/13 at 11:10 AM, revealed staff did not answer his/her call light in a timely manner which caused him/her to void or defecate on himself/herself. Resident #3 revealed he/she has had to wait up to two (2) hours before his/her call light was answered. Resident #3 also revealed the accidents made him/her feel "terrible".

Interview with Certified Nursing Assistant (CNA) #4, on 07/25/13 at 12:15 PM, revealed it was expected of the staff to answer all call lights as soon as possible.

F 241

F241

1. Resident #3 was provided incontinence care by nursing assistant on July 25 2013. Resident #3 was discharged from the center on July 31, 2013.
2. Director of Nursing/Assistant Director of Nursing/Nursing unit managers/Department Managers conducted interviews of interviewable residents to determine if any other call light responses/concerns as of August 5, 2013. Resident concern forms completed as necessary.
3. Re-education to center staff, nursing and non-nursing by August 16, 2013 regarding timely call light by Assistant Director of Nursing.

8/19

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013	
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
(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 241 Continued From page 2

Interview with the Unit Manager (UM), on 07/25/13 at 2:30 PM, revealed call lights would be answered as quickly as possible. She further revealed it was the responsibility of the staff to check each resident with a history of incontinence every two (2) to three (3) hours for toileting or changing.

Interview with the Assistant Director of Nursing (ADON), on 07/25/13 at 3:05 PM, revealed staff was to answer call lights as soon as possible and further revealed a resident should not have to wait more than two (2) or three (3) minutes before their call light was answered.

Interview with Administrator, on 07/25/13 at 3:17 PM, it was his expectation of the staff to answer all call lights within a reasonable amount of time and further stated that a wait time of two (2) hours was not acceptable.

F 242 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES
SS=D

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

F 241

4. Call lights response audits will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or Nursing Supervisors three times weekly at random, on all shifts and findings to be discussed monthly at the Performance Improvement meeting for further review and recommendations.

5. Completion date: 8/19/13

F 242 F242

1. Social Service Director/Admissions Director provided resident #4 and unsampled resident A with written times of smoke breaks as of August 7, 2013. Center staff, nursing and non-nursing, began verbally reminding residents of smoke break times on as of August 16. Unsampled residents B & C's food preferences were updated by the Food Service Manager as of August 9, 2013.

8/19

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
--	--

(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 242 Continued From page 3

Based on observation, interview, and record review, it was determined the facility failed to ensure resident meal choices were honored for two (2) unsampled residents (Unsampled Residents B and C). In addition, it was determined the facility failed to provide residents with choices about aspects of his/her life in the facility that were significant to residents for one (1) of eighteen (18) sampled residents and one (1) unsampled resident (Resident #4 and Unsampled Resident A) as evidenced by the residents were not informed timely of smoke breaks.

The findings include:

1. Review of tray line meal tickets on 07/23/13 between the hours of 5:15 PM and 5:40 PM revealed two unsampled residents were served food items listed as dislikes on their meal tickets. Unsampled Resident B had broccoll listed as a dislike; however, observation of tray line on 07/23/13 between the hours of 5:15 PM and 5:40 PM revealed Unsampled Resident B was served pureed broccoll salad, despite broccoll being listed as a dislike.
- Review of the tray line meal ticket on 07/23/13 between the hours of 5:15 PM and 5:40 PM revealed Unsampled Resident C had tomatoes listed as a dislike; however, observation on 07/23/13 between the hours of 5:15 PM and 5:40 PM revealed Unsampled Resident C was served chill, despite tomatoes being listed as a dislike.
- Interview with Cook #1, on 07/23/13 at 5:30 PM, revealed the chill served to residents contained both diced tomatoes and tomato juice.

F 242

2. Social Service Director /Admissions Director provided residents who chose to smoke written times of smoke breaks as of August 7, 2013. The Food Service Manager will update likes/dislikes for center residents as of August 9, 2013. 8/19
3. Director of Nursing/Assistant Director of Nursing re-educated center staff, nursing and non-nursing, to verbally remind residents of smoke breaks as of August 16, 2013. Food Service Manager re-educated dietary staff on following residents' food preferences regarding dislikes as of August 9, 2013.

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 242 Continued From page 4

Interview, on 07/24/13 at 2:00 PM, with the Food Services Director revealed a likes/dislikes list is completed within 24 hours resident arrival, and should be updated yearly. She revealed the procedure for ensuring the list of likes and dislikes was honored was for the cook to catch it, and if the cook did not catch it, one (1) of two (2) aides on the other side of the line should catch it. The Food Services Director revealed Unsampled Resident B should not have been served pureed broccoli salad, as broccoli was listed as a dislike. Also, the Unsampled Resident C should not have been served chili, as tomatoes were listed on his/her dislikes.

2. Record review revealed the facility admitted Resident #4, on 05/08/13, with diagnoses which included Generalized Pain, Chronic Obstructive Airway, Depression, Anxiety, Alzheimer's and Difficulty In Walking. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/13/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was moderately impaired in cognition.

During interview of resident's Quality of Life Assessment, on 07/25/13 at 1:00 PM, Resident #4 revealed the only activity he/she enjoyed was smoke breaks with peers. Resident #4 stated sometimes he/she was not allowed to smoke. Further questioning of Resident #4 revealed staff could arrive late to take residents out for smoke breaks but if residents were late for smoke break, they were not allowed to smoke. When observation of smoke break times noted in the resident's room, Resident #4 revealed he/she might be in the bathroom at the beginning of

F 242

4. Social Service Director/Admissions Director to randomly once a week interview residents who chose to smoke to determine they are being reminded of smoke break times and able to join smoke break activity. Interview results will be discussed monthly at the Performance Improvement meeting for further review and recommendations. Food Service Manager to randomly audit, at least 10 trays per week, at various meals, as they exit tray line to validate food preferences are being honored. Audit results will be discussed at Performance Improvement meeting monthly for further review and recommendations.

8/19

5. Completion date: 8/19/13

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
--	--

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

F 242 Continued From page 5

smoke break, or sleeping. Resident #4 also added sometimes he/she was out of his/her room and was not aware of the time. Resident #4 further revealed staff should be informing residents when staff were preparing to take residents outside to smoke.

3. Record review revealed the facility admitted Unsamed Resident A, on 03/13/12, with diagnoses which include Acute and Chronic Respiratory Failure, Congested Heart Failure, Depression, Anxiety, Hypertension, Muscle Weakness, and Pulmonary Heart Disease.

Review of the Roster Matrix and the list the facility provided revealed Unsample Resident A was alert, oriented and interviewable.

During interview of resident's Quality of Life Assessment, 07/25/13 at 4:50 PM, Unsamed Resident A revealed his/her dislikes of the activities offered by the facility and would like to be able to smoke more often and as much as he/she would like. Further Interview with Unsamed Resident A revealed he/she almost missed the smoke break that afternoon due to taking a nap when time for smoke break. Unsamed Resident A revealed his/her roommate woke Unsamed Resident A and he/she was able to go out to smoke but was only allowed to smoke one (1) cigarette instead of two (2) due to being late. Unsamed Resident A also revealed, at times, residents were not allowed to smoke if they arrive late. Unsamed Resident A revealed staff should be coming around to have residents prepare for smoke breaks. Unsamed Resident A further revealed he/she looked forward to smoke break and interactions with peers and staff.

F 242

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(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 242	Continued From page 6	F 242		
F 253 SS-D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations, on 07/23/13, 07/24/13 and 07/25/13, revealed resident care equipment including unlabeled and unbagged bedpans and urine hats in residents' bathroom floors of rooms 304, 306 and 318.</p> <p>The findings include: Observation, on 07/23/13 at 10:47 AM, on</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> Urinals/bedpans/urine hats in rooms 304, 306, and 318 were bagged, labeled and secured August 2, 2013 by Assistant Director of Nursing. Housekeeping Manger/Director of Nursing/Assistant Director of Nursing/Administrator conducted facility rounds to determine if urinals/bedpans/urine hats were labeled and secured on or before August 2, 2013. Any concerns were addressed immediately. 	8/19

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(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)	(X6) COMPLETION DATE
F 253	<p>Continued From page 7</p> <p>07/24/13 at 3:00 PM and on 07/25/13 at 10:15 AM, revealed two (2) unlabeled and unbagged bedpans and one (1) unlabeled and unbagged urine hat sitting on the bathroom floor in Resident room 304 .</p> <p>Observation, on 07/23/13 at 11:00 AM, on 07/24/13 at 3:10 PM and on 07/25/13 at 10:23 AM, revealed one (1) unlabeled and unbagged bedpan in the bathroom floor in Resident room 306 .</p> <p>Observation, on 07/23/13 at 11:12 AM, on 7/24/13 at 3:22 PM and on 07/25/13 at 10:26 AM, revealed one (1) unlabeled and unbagged urine hat in the bathroom floor in Resident room 318 .</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 07/25/13 at 12:15 PM, revealed all bedpans and urine hats were to be bagged in plastic and have the resident's name and room number written on them and hung off the floor.</p> <p>Interview with the Unit Manager (UM), on 07/25/13 at 2:30 PM, revealed it was unacceptable to have urinals, bedpans and urine hats lying on the floor without being bagged and labeled and placed off the floor for infection control purposes.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/25/13 at 3:05 PM, revealed it was the expectation of the staff to bag all urine hats, bed pans and urinals in plastic bags, label each with the resident's name and room number and suspend them off the floor to prevent any issues with infection control.</p>	F 253	<p>3. Director of Nursing/Assistant Director of Nursing /Unit Managers/Nursing Supervisors re-educated nursing staff on proper labeling and storage of urinals/bedpans/urine hats as of August 9, 2013.</p> <p>4. Housekeeping/Director of Nursing/Assistant Director of Nursing/Administrator will conduct center rounds twice weekly to verify proper labeling and storage of urinals/bedpans/urine hats. Findings will be discussed in monthly Performance Improvement meeting for further review and recommendation.</p> <p>5. Completion date: 8/19/13</p>	8/19
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 282 | Continued From page 8
SS=D | PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to ensure services were provided according to the written plan of care for one (1) out-of-eighteen (18) sampled residents (Resident #6). the facility failed to ensure Resident #6 received the snack as ordered by the Registered Dietitian and per the care plan.

The findings include:

Review of the facility's policy titled "Care Plan - Interdisciplinary", effective date 01/08, revealed the care plan was comprehensive for each resident including measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs.

Record review revealed the facility admitted Resident #6, on 06/04/13, with diagnoses which include Aftercare for Hip Fracture, Dementia, Dysphagia, Hypertension, Gastroesophageal Reflex Disease, Anxiety, Congested Heart Failure, and Generalized Pain.

Review of Resident #6's record revealed an Interdisciplinary Progress Notes written by the

F 282

F282

1. Resident #6 has received thickened chocolate milk per the Dietician recommendation and their care plan as of July 26, 2103 by the nurse or nursing assessment. 8/19

2. Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers reviewed previous 60 days of Dietary Recommendations and resident care plans to validate recommendations had been implemented and care plans were being followed as of August 9, 2013. Any discrepancies were addressed at that time.

3. Director of Nursing/Assistant Director of Nursing/Nursing Unit managers re-educated nursing staff on following resident care plans, to include snack pass as of August 9, 2013.

The Food Service Manager re-educated dietary staff to preparing snacks in accordance with the residents plan of care as of August 9.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
--	--

(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 282 Continued From page 9

Registered Dietitian, dated 07/16/13, to add Chocolate Milk twice a day between meals to the resident's diet to boost protein intake and calorie intake to improve the resident's wound healing and weight.

Review of Resident #6's care plan for Potential Alteration in Nutrition Status revealed a new focus area, dated 07/16/13, of significant weight loss and wound. Further review revealed new intervention, dated 07/16/13, chocolate milk BID (twice a day) with snack pass.

Review of Interdisciplinary Communication to Nutrition Services, on 07/22/13, revealed Resident #6 was changed from Nectar Thickened Liquids to Honey Thickened Liquids.

Observation of 2:00 PM snack pass, on 07/24/13, revealed Resident #6 did not receive Chocolate Milk for a snack.

Interview with Certified Nursing Assistant (CNA) #1, on 07/24/13 at 2:55 PM, revealed there was not any chocolate milk placed on the snack cart for Resident #6.

Interview with CNA #2, on 07/24/13 at 3:00 PM, revealed she normally worked the day shift on that unit and she had never seen chocolate milk on the snack cart.

Interview with Registered Nurse (RN) #1, on 07/24/13 at 11:40 AM, revealed Resident #6 had been receiving chocolate milk with snacks which came from the kitchen. RN #1 stated staff had not been recording the percentage of intake of chocolate milk since it was not an actual Physician's order and, therefore, was not

F 282

4. Director of Nursing/Assistant Director of Nursing/Nursing Unit managers will conduct observations on center snack times three times weekly, at varied times, to validate residents are receiving snacks per the care plan. Results of snack observations will be discussed at the Performance Improvement Committee meeting monthly for further review and recommendation.

The Food Service Manager will audit snack preparation three times weekly to validate snacks are being prepared in accordance with residents' plan of care. Results of snack preparation will be discussed at the Performance Improvement Committee meeting monthly for further review and recommendation.

5. Completion date: 8/19/13

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 necessary to record on Medication Administration Record (MAR) or Treatment Administration Record (TAR). Interview with Kitchen Manager, on 07/24/13 at 11:45 AM, revealed Resident #6 had been receiving a snack of chocolate milk. The Kitchen Manager stated the milk was being sent out of the kitchen for the 10:00 AM and 2:00 PM snacks. Interview with the Kitchen Manager, 07/24/13 at 3:05 PM, revealed the milk was thickened by kitchen staff then placed in refrigerator at the nursing station for nursing to deliver to resident. The Kitchen Manager then looked inside the refrigerator at the nursing station and confirmed chocolate milk for Resident #6 was not present.	F 282		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation interview, record review and review of the facility's policy, it was determined the facility failed to ensure food was prepared in a form to meet resident needs for one (1) of eighteen (18) sampled residents as evidenced by Resident #6 was care planned for honey thickened chocolate milk with snacks and observation, on 07/24/13, revealed Resident #6 did not receive honey thickened chocolate milk. The findings include:	F 367	F367 1. Resident #6 has received thickened chocolate milk per the Dietician recommendation and their care plan as of July 26, 2013 by the nurse or nursing assistant. 2. Food Service Manager to audit meal tray tickets and center snack report to validate appropriate diets, diet modifications/consistencies are correct for all residents on or before August 9, 2013.	8/19

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 367 Continued From page 11

Review of facility's policy "Diet Orders", effective date 07/08, revealed diets were prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care.

Review of facility's policy "Thickened Liquids", effective date 07/08, revealed the Nutritional Department would provide thickened liquids as ordered for all meal trays, snacks, medication administration, and hydration snack.

Record review revealed the facility admitted Resident #6, on 06/04/13, with diagnoses which include Aftercare for Hip Fracture, Dementia, Dysphagia, Hypertension, Gastroesophageal Reflux Disease, Anxiety, Congested Heart Failure, and Generalized Pain.

Review of Resident #6's record revealed an Interdisciplinary Progress Notes written by the Registered Dietitian, dated 07/16/13, to add Chocolate Milk twice a day between meals to Resident #6's diet to boost protein intake and calorie intake to improve the resident's wound healing and weight.

Review of Interdisciplinary Communication to Nutrition Services, on 07/22/13, revealed Resident #6 was changed from Nectar Thickened Liquids to Honey Thickened Liquids.

Observation of the 2:00 PM snack pass, on 07/24/13, revealed Resident #6 did not receive Chocolate Milk for a snack.

Interview with Licensed Practical Nurse (LPN) #1, on 07/24/13 at 3:10 PM, revealed she went to give the chocolate milk at both the 10:00 AM and 2:00 PM snack breaks but stated the milk was at

F 367

3. Food Service Manager to re-educate dietary staff on preparing and serving appropriated diets, diets modifications/consistencies, to include snacks on or before August 9, 2013. 8/19
4. Food Service Manager to audit meal trays and snack preparation to validate appropriate diets, diet modifications/consistencies are being prepared for service three times weekly at varied meal/snack times. Results of audit will be discussed at the Performance Improvement Committee meeting monthly for further review and recommendation.
5. Completion date: 8/19/13

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 367	Continued From page 12 the wrong consistency to give to Resident #6 at both the 10:00 AM and 2:00 PM snack times so LPN #1 revealed she offered the resident juice instead. The Kitchen Manager was present during the interview and revealed kitchen staff must have prepared the milk incorrectly according to the diet order for the resident.	F 367		
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and review of the facility's policy, it was determined the facility failed to prepare, distribute and serve food under sanitary conditions. Observation during the evening meal on 07/23/13 revealed the temperature of broccoll salad to be 60 degrees Fahrenheit. The findings include: Review of the facility's "Food Preparation Policy", revised 07/08, revealed the Cook insured foods were held at the appropriate temperatures, and all nutrition staff were responsible for using utensils appropriately to prevent cross	F 371		

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

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

F 371 Continued From page 13 contamination.

Interview with the Food Services Director, on 07/23/13 at 5:25 PM, revealed cold items should be served at below 40 degrees Fahrenheit.

Observation of tray line temperatures, on 07/23/13 at 5:15 PM, revealed facility staff measured the temperature of broccoli salad to be 60 degrees fahrenheit. The same thermometer, unsanitized, was used to take the temperature of both the mechanical soft and the pureed broccoli salad, both of which were 52 degrees Fahrenheit.

Interview with Cook #1, on 07/23/13 at 5:23 PM, revealed she had been running late in preparation of the broccoli salad, and it didn't get cold enough prior to service. Cook #1 went on to reveal she did not consider it a safety issue as the broccoli salad did not get properly cooled, and had not been left out for any length of time.

Interview with the Food Services Director, on 07/23/13 at 5:25 PM, revealed cold items should not be above 40 degrees Fahrenheit. Further interview revealed she considered it a "danger zone" if items such as broccoli salad remained at temperatures above 41 degrees Fahrenheit for two (2) hours or more.

Continued observation of tray line, on 07/23/13 at 5:40 PM, revealed the broccoli salad, regular, mechanical soft, and pureed, were all served at the temperatures taken. Although staff placed ice beneath the items on the steam table, the regular broccoli salad was next to a hot food item, chill.

Interview, on 07/25/13 at approximately 11:00 AM, with the Dietitian revealed salad should be served

F 371

F371

1. Food Service Manager re-educated cook #1 on July 26, 2013 on appropriate food temperatures.
2. Food Service Manager checked food temps during preparation and at time of services for meals at varied meal times during the week of August 5, 2013 thru August 8, 2013. Any concerns were addressed/corrected immediately.
3. Food Service Manager re-educated dietary staff on food temps on or before August 9, 2013.
4. Food Service Manager to conduct random audit on meal temperatures three times weekly. Findings will be discussed at monthly Performance Improvement meeting for further review and recommendations.
5. Completion date: 8/19/13

8/19

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2013
NAME OF PROVIDER OR SUPPLIER GRANT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097	

(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 371	Continued From page 14 at 41 degrees Fahrenheit or below. Regarding the broccoli salad, the Dietitian went on to reveal it would be an error on the part of the kitchen to serve it if not cooled to the proper temperature. The Dietitian went on to reveal if cold food items were not cooled properly, bacteria could grow, and it could create toxins. The Dietitian revealed, if cold food items were not properly cooled, they may need to be discarded and a substitute of like nutritional value served in their place.	F 371		

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
--	--

(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
--------------------	--	---------------	---	----------------------

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Plan Approval: 1986, 1996

Survey under: 2000 Existing

Facility type: SNF/NF

Type of structure: One story Type V(111) with partial basement

Smoke Compartments: 4

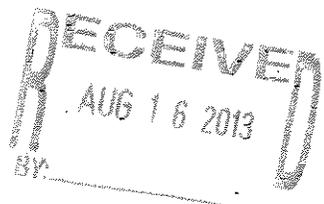
Fire Alarm: Full fire alarm system installed in 1986

Sprinkler System: Automatic (dry) sprinkler system installed in 1986

Generator: Type II natural gas installed in 201

A standard Life Safety Code survey was conducted on 07/25/13. Grant Center was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000



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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

8/16/13

Efficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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

PRINTED: 10/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
---	--

(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}	<p>INITIAL COMMENTS</p> <p>An On-site revisit was initiated on 10/15/13 and concluded on 10/17/13. The facility was found to be in compliance as alleged in the acceptable POC on 08/19/13.</p>	{F 000}		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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