

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

PRINTED: 03/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>
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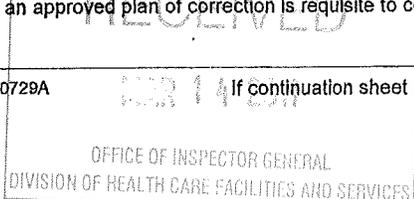
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F 000	INITIAL COMMENTS	F 000		
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident #10) assessed by an interdisciplinary team to self-administer medications.</p> <p>The findings include:</p> <p>Record review of the facility policy Medication Administration-General Guidelines effective date 2/1/10 revealed:</p> <ul style="list-style-type: none"> <li>Medications are administered at the time they are prepared. Medications are not pre-poured.</li> <li>Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.</li> </ul> <p>Observation of Resident #10 on 02/15/11 during initial tour at 8:30am revealed three (3) pills a green, a white, and a yellow in a plastic medication cup, on a round wooden table. Further observation on 02/15/11 at 10:05am</p>	F 176	<p><b>F-176</b></p> <p>The nurse who allowed resident # 10 to administer her own medication was counseled and educated on the campus Medication Administration Guideline.</p> <p>The DHS or her designee will audit the charts of resident who do self administer their medication and verify that those residents have been assessed by licensed staff and are safe to self administer medication.</p> <p>All licensed staff will be in serviced on our Medication Administration Guideline on 3/11/11. The DHS or her designee will complete staff medication administration check-offs with nurses 4 times a week for 4 weeks, 2 times a week for 4 weeks and weekly for 4 weeks.</p> <p>The administration check-offs will be monitored by the interdisciplinary monthly during our QA meeting.</p>	3/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine A. [Signature] TITLE: Executive Director (X6) DATE: 3/11/11

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.

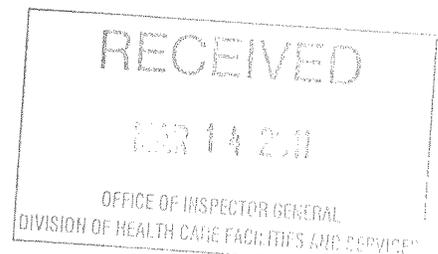
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F 176	Continued From page 1 revealed Resident #10 sitting at the round wooden table with the three pills in the plastic medication cup. Continued observation on 02/15/11 at 10:10am revealed Resident #10 was drinking a clear tan liquid while taking all three pills.  Review of the clinical record for Resident #10 revealed the resident was admitted to the facility with diagnoses of anemia, depression, edema, and cataracts. The facility completed an initial Minimum Data Set Assessment on 02/06/11 which indicated the resident cognition of fifteen (15). Further review of the comprehensive care plan did not address resident's desire to self administer medications.  Interview with LPN #1 on 02/15/11 at 8:35am in room #508 revealed that she had left the morning medication in Resident #10's room, per the resident's request. She further stated that medications should never be left with a residents and that she had been trained on medication administration.  Interview on 02/15/11 at 10:15am revealed that she was unaware that Resident #10 had not taken the medication until 10:10 am.  Interview with the DON on 02/15/11 at 9:00am in the conference room revealed that staff had been trained on medication administration and that she was aware that sometimes staff leave medications in resident's room. She further revealed that by not observing the administration of medications, there was no way to prove if residents are taking their medication.	F 176		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		



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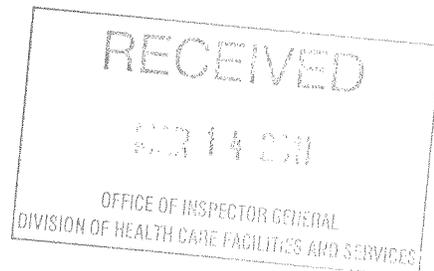
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F 226	<p>Continued From page 2</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed ensure implementation of written policy to do reference checks on five (5) of ten (10) sampled staff upon hire.</p> <p>The findings include:</p> <p>The HR Policies and Procedures "References for Potential Employees" states that the department supervisor will conduct reference checks on the potential employee prior to extending a conditional offer of employment. Completed reference/background checks will be documented and placed in the employee's personnel file when hired. All applicants being considered for employment must provide former employee references.</p> <p>Record review of reference check forms for Dietary Aids #8, #9, and #10 revealed that the "For Office Use Only" sections were empty, with no documentation noted. Reference check forms for Licensed Practical Nurse (LPN) #5 and Certified Nursing Assistant (CNA) #1 revealed that the "For Office Use Only" section was empty, with no documentation noted.</p> <p>Interview with the Payroll Coordinator on 02/17/11 at 10:46am revealed that the Department Heads</p>	F 226	<p><b>F-226</b></p> <p>Reference checks were immediately completed on those employees who did not have reference checks in their employee file. The Payroll Coordinator and Department Leaders are in serviced on completing reference checks on potential new hires.</p> <p>The BOM or her designee will audit current employee files to identify those files that do not have reference checks in place. Those identified without having reference checks will have checks completed immediately.</p> <p>During the employee selection process the department leader will complete reference checks on potential new hires. The Payroll Coordinator will review the Candidate Application Packet and verify that reference checks are completed.</p> <p>The Business Office Manager will audit new employee files by using the Personnel File Checklist Form (D) after we have our New Hire General Orientation. The results will be discussed with the IDT during our monthly QA meeting.</p>	3/25/11
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F 226	Continued From page 3 are to conduct reference checks. Each Department Head is to call at least two (2) references and place information on paperwork provided. The Assistant Director of Health Services is to conduct reference checks on nursing staff and the Director of Food Services is to conduct reference checks for dietary staff. The Payroll Coordinator further stated that she was responsible to monitor to make sure everything was in the staff members' file. If a reference check was not completed, she is supposed to let the Director know that the process was not completed.  Interview with the Assistant Director of Health Services on 02/17/11 at 11:10am revealed that CNAs and LPNs reference checks were completed by her and if the reference checks were not written down, then it was not completed.  Interview with the Director of Food Services on 02/17/11 at 11:16am revealed he was to conduct reference checks. The Director of Food Services further stated they check references for staff's reliability and background information.  Interview with the Administrator on 02/17/11 at 11:20am revealed she was not aware of reference checks not being completed and that reference checks determine staff character.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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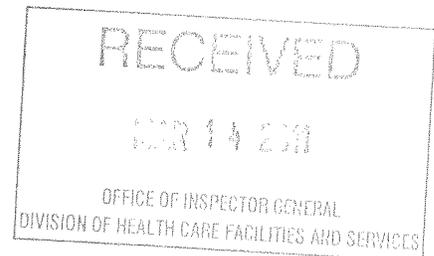
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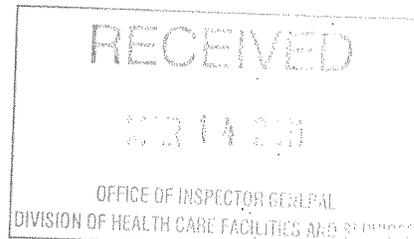
F 253	<p>Continued From page 4</p> <p>This <b>CONDITION</b> is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide residents with effective maintenance services. Wheelchairs were noted to have cracked arm rests and torn or cracked leg rests.</p> <p>The findings include:</p> <p>Observation of the wheelchair for Resident #9 on 02/15/11 at 10:56am revealed a torn leg rest on the right side.</p> <p>Observation of wheelchairs during the lunch meal in the Health Center Dining Room on 02/15/11 at 12:00pm revealed cracked arm rests for four (4) unsampled residents.</p> <p>Observation of the wheelchair for Resident #2 on 02/15/11 at 11:25am revealed cracked arm rests.</p> <p>Observation of wheelchairs during the lunch meal in the Health Center Dining Room on 02/16/11 at 12:15pm revealed cracked arm rests for Resident #1 and Resident #6. Cracked arm rests were also seen on three (3) unsampled resident's wheelchairs. A torn leg rest was noted for one (1) unsampled resident.</p> <p>Interview with the maintenance director on 02/17/11 at 10:45am revealed he has worked at the facility for three years. He stated that he is responsible for maintaining equipment, including wheelchairs. He stated he does not have a scheduled time that he checks on resident wheelchairs, but he does spot checks when making rounds through the building. He does not keep a log of this. He also takes complaints from</p>	F 253	<p><b>F-253</b></p> <p>The wheelchairs with cracked arm rest and/or leg rests have been replaced with new arm rest and leg pads.</p> <p>The Director of Plant Operations (DPO) checked all of the campus wheelchairs and equipment to determine if others were damaged. Those identified as damaged were repaired.</p> <p>The DPO will use the Wheelchair Assessment Form (C) to audit current wheelchairs and log new wheelchairs. The DPO will complete this form weekly for 4 weeks and monthly there after.</p> <p>The Wheelchair Assessment Form will be reviewed and monitored by the Interdisciplinary Team monthly during our QA Meeting.</p>	3/25/11
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F 253	Continued From page 5 residents or staff if something needs to be fixed. Work orders can be filled out by the staff and he picks up the work orders throughout the day and makes the necessary repairs. He stated he has had no complaints of cracked wheelchairs arms or torn leg rests. He was not aware that so many were in need of repair. He acknowledged that potential problems with cracked wheelchair arms and torn leg rests might be infection control with not being able to properly clean the wheelchairs and also that if the arm rests were cracked badly someone with fragile skin could acquire a skin tear. He stated nursing is responsible for cleaning the wheelchairs and he does not have a policy on maintaining wheelchairs.  Interview with the Director of Nursing on 02/17/11 at 2:25pm revealed she has worked at the facility almost three and one-half years. She stated the CNAs (Certified Nursing Assistant) clean the wheelchairs weekly on night shift and there is a schedule they use to know which night to clean them. A copy of the cleaning schedule was made available. She stated if the CNA cleaning the wheelchair notices that a wheelchair needs repaired, they should fill out a work order for maintenance to repair the wheelchair. A work order can be filled out at any time by any staff member as well.	F 253		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the RAI	F 272		



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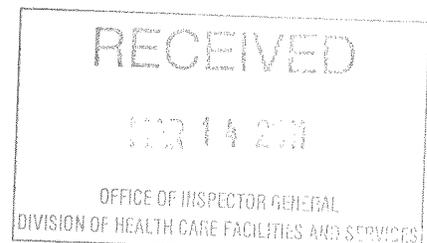
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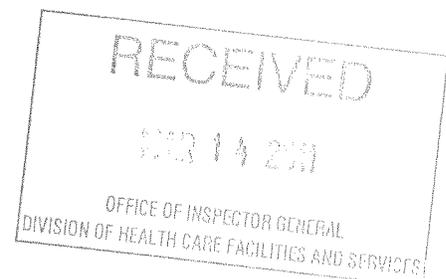
F 272	<p>Continued From page 6 specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct an initial comprehensive assessment with Utilization Guidelines specified as part of the Resident Assessment Instrument (RAI), and perform an ongoing assessment for appropriate needs and services on three (3) of sixteen (16) sampled residents (Resident's #6, #9, and #13). An Initial RAI was not completed on Resident #9 and #13. An ongoing assessment was not completed to evaluate the need for a positioning device on resident #9, and areas that triggered in the Care Area Assessment (CAA) were not</p>	F 272	<p><b>F- 272</b></p> <p>Resident #6, #9 and #13 discharged from our campus post annual survey. Resident #9 and resident #13 have readmitted. An initial RAI will be completed timely on both residents. Assessments will be completed on going to identify needs specific to the resident care. Care plans will be developed resulting from areas triggered in the Care Area Assessment. The MDS Coordinators were inserviced on the RAI requirements and care plans.</p> <p>All residents who are admitted to our campus have the potential to be affected by this practice. Current resident charts will be audited by the MDS Coordinators or designee (E) to identify if assessments are completed timely and care plans are developed as a result of areas triggered by the Care Area Assessments.</p> <p>Current resident charts will be audited monthly by the DHS or Designee (J) to verify that Initial Comprehensive assessments are being completed timely and individualized care plans are being developed by areas triggered by the Care Area Assessments.</p>	3/25/11
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F 272	<p>Continued From page 7</p> <p>further assessed to develop an individualized plan of care on Resident #6.</p> <p>The findings include:</p> <p>Review of the Facility's policy titled Clinical Documentation Systems, which was not dated, revealed that a comprehensive Minimum Data Set (MDS) with CAAs will be completed for the Medicare 5 day or the Medicare 14 day, Medicaid, or private pay assessment.</p> <p>Review of the Facility's policy on Skilled Nursing Assessment and Data Collection, which was not dated, revealed that a dally assessment should be completed to include a comprehensive head to toe assessment that includes each body system and skilled service. This form may be used for acute episodes, change in condition, or episodic events.</p> <p>Review of Resident #9's record revealed an admission date of 01/10/11 with an admitting diagnoses of Cerebral Vascular Accident, Diabetes, Hypertension, Hyperlipidemia, Urinary Retention, Benign Prostatic Hyperplasia, Dysphagia, and Left sided Hemiplegia. The initial Minimum Data Set (MDS) on the chart was not signed or dated as complete.</p> <p>Observation of Resident #9 on 02/15/11 at 10:56am revealed the resident sitting in their room in a wheelchair. The left leg was tied to the wheelchair leg with a white piece of fabric which the resident identified as Thrombo Embolic Deterrent (TED) hose. The resident reported having leg spasms for over a week, which caused his leg to fall off of the wheelchair. The resident further reported that the facility staff had been</p>	F 272	<p>The DHS/ED will verify with the MDS Coordinators and document on the Morning Report (F) any MDS Concerns including assistance needed and address those concerns accordingly. The MDS Assessment Audit Forms will be reviewed by the Interdisciplinary Team monthly during the Quality Assurance meeting.</p>	



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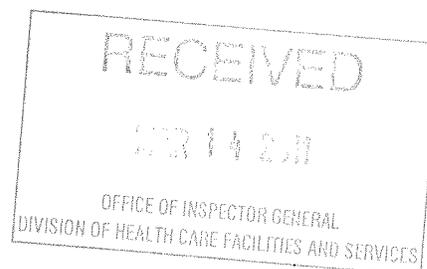
F 272	<p>Continued From page 8</p> <p>tying the TED hose around the resident's leg and wheelchair to prevent it from falling off the wheelchair leg rest.</p> <p>Observations on 02/15/11 at both 2:25pm and 4:30pm revealed the resident still sitting in the wheelchair with the left leg tied to the leg rest of the wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 02/15/11 at 4:30pm revealed that the CNA had tied the resident's leg to the wheelchair. The CNA reported that the resident had requested to be tied to the wheelchair and the staff was not allowed to refuse a resident's request. The CNA confirmed that using a TED hose to position or splint could potentially cause skin problems. The CNA confirmed using the TED hose for over a week, but had not informed the nurse due to the fact that they were already aware and had also been tying the patient's leg to the wheelchair.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 02/15/11 at 4:35pm revealed that the nurse was not aware that the resident's leg had been tied to the wheelchair during multiple observations. The nurse confirmed using the TED hose to tie the resident's leg to the wheelchair could cause potential problems with circulation, skin integrity, and cause potential problems with contractures and falls. The nurse removed the TED hose at the time of the interview and a depression was noted to the lateral aspect of the left ankle where the knot had rested against the skin. The nurse did not perform an assessment to evaluate the skin or muscle tone of the client.</p> <p>Interview with Physical Therapy Assistant (PTA) #2 on 02/15/11 at 4:40pm revealed that the</p>	F 272		
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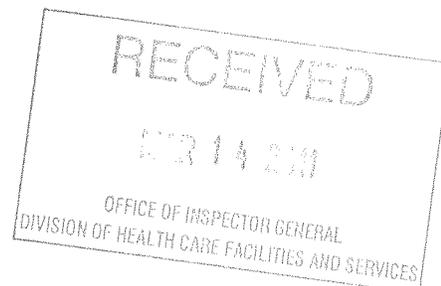
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F 272	<p>Continued From page 9</p> <p>physical therapy department does a weekly and a monthly assessment of the residents. The PTA reported the resident had problems with muscle tone which resulted in the muscle spasms. The PTA also reported being aware of the residents use of the TED hose but did not see where using the hose could cause any potential risks, and also reported not knowing of any other type device that could be used to assist the resident. The PTA also revealed not informing nursing staff of the TED hose being tied around the resident's leg. The PTA did confirm charting on the muscle tonicity of the resident, but did not document the resident using a TED hose to assist in positioning the leg on the wheelchair.</p> <p>Interview with the Physical Therapy Program Director on 02/16/11 at 10:30am revealed that the therapy department does evaluate residents for splints and positioning devices. The Program Director revealed she was not aware of the resident being tied to the wheelchair with a TED hose. She also confirmed that inappropriate use of TED hose could cause problems with skin integrity and circulation. She revealed that each therapist was responsible for evaluating the needs of the resident but confirmed she was responsible for ensuring that the assessment was being completed.</p> <p>Interveiw with Registered Nurse #1 on 02/16/11 at 11:15am revealed that the signature and date on the MDS indicated completion of the RAI. The RN confirmed she did not sign and date the MDS signifying completion of the assessment. The RN stated that the signature page had been overlooked.</p> <p>Interview with LPN #3 on 02/17/11 at 11:20am</p>	F 272			



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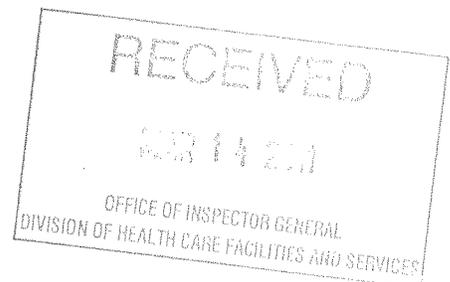
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/17/2011
NAME OF PROVIDER OR SUPPLIER  GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 272	<p>Continued From page 10</p> <p>revealed that the nurse had been aware of the resident being tied to the wheelchair with TED hose. She stated that it was removed at that time, but did not do an assessment to determine if there had been a change in the resident's condition. The LPN stated she had asked Physical Therapy if they were aware, but never followed through to ensure the resident was evaluated. The LPN confirmed she should have assessed the resident and communicated better with physical therapy to ensure the resident's needs were met.</p> <p>Interview with the Director of Nursing (DON) on 02/17/11 at 4:10pm revealed all staff were responsible for reporting any change in the resident's condition. She stated all of the staff members should be assessing the residents daily for any change in condition, or a need for specialized services. All staff should be communicating across roles and shifts to ensure the resident's needs are met. The DON confirmed that tying the resident with TED hose could cause potential problems to the skin integrity and circulation. The DON confirmed that the current system in place to monitor status condition of the residents was not working. The DON revealed that she was ultimately responsible for ensuring that the staff was assessing the residents for needs, services, and condition changes. The DON reported multiple issues have arose recently with MDS 3.0, but also confirmed there was no formal system in place to ensure the RAI was being completed accurately and timely. The DON stated the importance of an accurate and timely assessment so that a plan of care can be formulated. The DON confirmed ultimate responsibility for ensuring the RAI was completed and signed.</p>	F 272		



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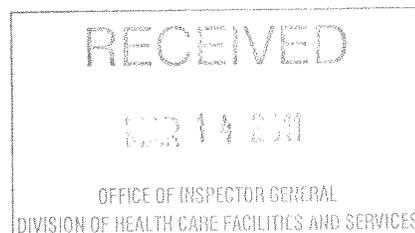
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F 272	Continued From page 11  Record review for Resident #6 revealed the facility did not complete an admission assessment and care plan, as directed by the facility policy, for Resident # 6. Resident # 6 was admitted on 12/20/10 with admitting diagnoses of CAD, Dysphagia, Congenital Clotting Factors, HTN, Hypothyroidism, Left-sided Heart Failure, GERD, Pacemaker, Syncope, and Pulmonary Heart Disease. The plan of care on Resident #6's chart did not include needs triggered on the Care Area Assessment (CAA). The triggered needs to be addressed on the care plan are: ADL Function, Falls, Nutrition, Dehydration, and Pressure.  Interview with Registered Nurse (RN) #1 on 02/17/11 at 9:15am revealed the triggered needs had not been included in the Care Plan.  Record review of Resident #13's record revealed that Resident #13 had an original admission date of 10/27/10. Resident #13 was discharged to the hospital on 11/8/10. The Minimum Data Set (MDS) revealed that a five (5) day schedule assessment was completed on 11/09/10. Resident #13 was readmitted on 12/02/10 from the hospital. A readmission assessment was completed on 12/02/10. A fourteen (14) day schedule assessment was completed on 12/22/10 and a thirty (30) day scheduled assessment was completed on 12/21/10. Resident #13 was discharged from the facility on 01/06/11.  Interview with the Assistant MDS Coordinator, on 02/17/11 at 11:00am, revealed that she was aware that CMS required them to do an initial	F 272		



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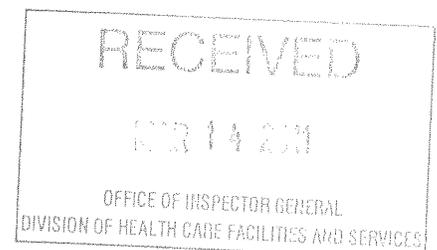
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F 272	Continued From page 12 admission assessment with readmission assessments because it would bring up the cause on the assessment. If they do not have an initial assessment, they would not know what was triggered on the MDS to do a thorough care plan.  Interview with the Director of Health Services on 02/17/11 at 4:06pm revealed that since MDS 3.0 has come out there has been some issues. They have nothing formal to check to see if MDS's are completed. They realize MDS's are not completed when they receive their billing for medicare residents. The Director of Health Services further stated that there should have been an admission assessment completed on Resident #13 and technically the plan of care would not be thoroughly completed.  Interview with the Administrator on 02/17/11 at 4:00pm revealed she was aware of some issues with MDS 3.0 especially the lengthy paper work. She further revealed she was aware of quarterly's being done late, but not aware of MDSs coded wrong. The Administrator further stated that without accurate MDS's residents would not receive one hundred percent (100%) of care needed.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by:	F 276	F-276  Resident #7 next quarterly assessment will be completed timely. Both MDS Coordinators were inserviced on RAI Requirements and Care Plans.  All residents who are admitted to our campus have the potential to be affected by this practice. Current	3/25/11



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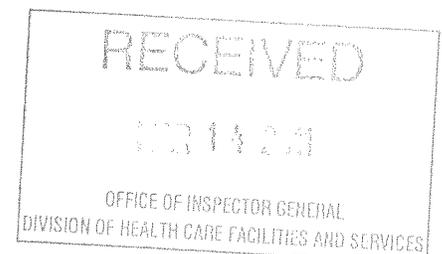
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F 276	<p>Continued From page 13</p> <p>Based on record review and interview it was determined the facility failed to complete minimum data set (MDS) assessments at least every three (3) months, not to exceed ninety-two (92) days for one (1) of sixteen (16) sampled residents.</p> <p>The findings include:</p> <p>Record review of the clinical record for Resident #7 revealed the resident had a quarterly MDS assessment completed on 08/16/10 and an annual MDS assessment completed on 01/07/11, one hundred forty-four (144) days after the last quarterly assessment. A quarterly MDS assessment was not completed in November 2010, not to exceed ninety-two (92) days.</p> <p>Interview with the MDS coordinator on 02/16/11 at 10:50am revealed she had worked at the facility since 2006. She stated she knew a quarterly assessment should have been completed in between the 08/16/10 assessment and the 01/07/11 assessment for Resident #7; however, she got behind on completing the MDS assessments when MDS 3.0 was implemented in October 2010. She stated she was trying to catch up on the resident assessments and since Resident #7 was a private pay resident his assessment was pushed back while the Medicare residents' assessments were caught up in order to continue to collect payment from Medicare.</p> <p>Interview with the Director of Nursing (DON) on 02/17/11 at 4:10pm revealed that she is ultimately responsible to ensure the MDS assessments are being done and done correctly. She stated when MDS 3.0 hit in October 2010 things started getting behind. The DON looks at the calendar of</p>	F 276	<p>resident charts will be audited by the MDS Coordinators or designee (E) to identify if assessments are completed timely.</p> <p>Current resident charts will be audited monthly by the DHS or Designee (J) to verify that quarterly assessments are being completed timely.</p> <p>The DHS/ED will verify with the MDS Coordinators and document on the Morning Report any MDS Concerns including assistance needed and address those concerns accordingly. The MDS Assessment Audit Forms will be reviewed by the Interdisciplinary Team monthly during the Quality Assurance meeting.</p>		



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F 276	Continued From page 14 which assessments are due and which ones are done. She stated there was no formal process to monitor if the assessments were being done, just meeting with the MDS coordinator on what is due and what is behind. When asked about private pay residents she stated she was not aware of a regulation that states private pay residents have to have their MDS assessments done on the same schedule as Medicare residents. However, their parent corporation requires them to do the MDS reviews for private pay residents on the same time table as the Medicare residents. The DON stated that when the MDS coordinator got behind in the MDS assessments, the parent corporation required them to make the Medicare residents a priority, and to do the assessments for the private pay residents last.	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		



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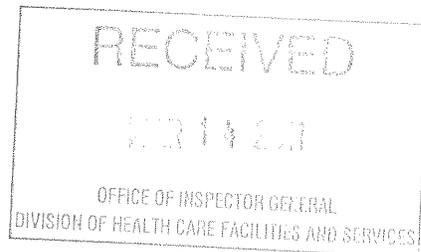
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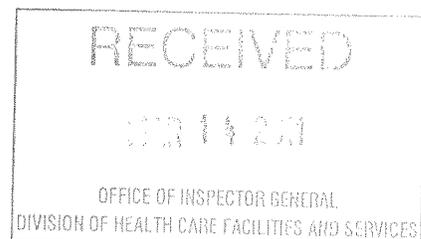
F 279	<p>Continued From page 15 under §483.10(b)(4).</p> <p>This REQUIREMENT Is not met as evidenced by: Based on observations, interview, and record review it was determined the facility failed to develop an individualized care plan for three (3) of sixteen (16) residents (#6, #9, and #13). Areas triggered in the Care Area Assessment (CAA) were not utilized to develop an Individualized Care Plan for Resident's # 6, #9, and #13.</p> <p>The findings include:</p> <p>Review of the facilities policy, Clinical Documentation System revealed an initial assessment will be initiated with a temporary care plan within twenty-four (24) hours and completed Care Plan within seventy-two (72) hours of admission.</p> <p>Record review of Resident #6's chart on 02/15/11 at 3:45pm revealed: Resident #6 was admitted to the facility on 12/20/10 with medical diagnosis of Coronary Artery Disease, Dysphagia, Hypothyroidism, Congenital Clotting Factors, Hypertension, Gerd, Pacemaker, Syncope, and Heart Disease. The facility failed to follow their policy of initiating an assessment and care plan within seventy-two (72) hours of admission. A comprehensive assessment was not initiated until 02/01/11. In addition, a Comprehensive Care Plan based on needs areas triggered by the MDS assessment was not initiated.</p> <p>Interview with Registerd Nurse (RN) #1, on 02/17/11 at 9:15am, revealed RN #1 could not</p>	F 279	<p><b>F- 279</b></p> <p>Resident #6, #9 and #13 discharged from our campus post annual survey. Resident #9 and resident #13 have readmitted. The initial care plans are updated and in place. Both MDS Coordinators were inserviced on RAI requirements and Care Plans.</p> <p>All residents who are admitted to our campus have the potential to be affected by this practice. Current resident charts will be audited by the MDS Coordinators or designee (E) to verify that the initial individualized care plans are in place and that comprehensive assessments are completed timely.</p> <p>Current resident charts will be audited monthly by the DHS or Designee (J) to verify that Initial Comprehensive assessments are being completed timely and individualized care plans are being developed by areas trigged by the Care Area Assessments.</p> <p>The DHS/ED will verify with the MDS Coordinators and document on the Morning Report (F) any MDS Concerns including assistance needed</p>	3/25/11
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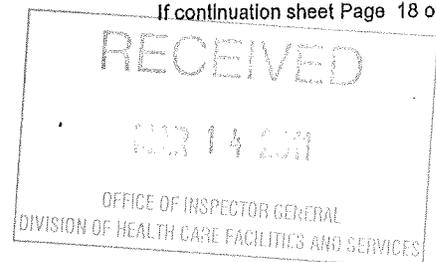
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F 279	<p>Continued From page 16</p> <p>locate documentation of a care plan for Resident #6 initiated from the triggered needs identified by the MDS. The date of the MDS was 02/01/11, which was thirty-one (31) days after admission.</p> <p>Record review of Resident #13's record revealed that Resident #13 had an original admission date of 10/27/10. Resident #13 was discharged to the hospital on 11/8/10. The Minimum Data Set (MDS) revealed that a five (5) day scheduled assessment was completed on 11/09/10. Resident #13 was readmitted on 12/02/10 from the hospital. A readmission assessment was completed on 12/02/10. A fourteen (14) day scheduled assessment was completed on 12/22/10 and a thirty (30) day scheduled assessment was completed on 12/21/10. Resident #13 was discharged from the facility on 01/06/11.</p> <p>Interview with the Assistant MDS Coordinator on 02/17/11 at 11:00am revealed that she was responsible to do care plans and update as needed. CMS required them to do an initial admission assessment with a readmission assessment, because it would bring up the cause on the assessment. If the did not have an initial assessment, they would not know what was triggered on the MDS to do a thorough care plan. Without providing the right care, possible injuries could occur to residents.</p> <p>Interview with the Director of Health Services on 02/17/11 at 4:06pm revealed she was aware that readmission assessments were not full assessments and technically the plan of care would not be thoroughly complete without a full assessment. The Director of Health Services further stated there should have been an</p>	F 279	and address those concerns accordingly. The MDS Assessment Audit Forms will be reviewed by the Interdisciplinary Team monthly during the Quality Assurance meeting	



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F 279	<p>Continued From page 17</p> <p>admission assessment completed on Resident #13.</p> <p>Interview with the Administrator on 02/17/11 at 4:00pm revealed she was aware that MDS's help the care plan to be more accurate. The Administrator further stated that without accurate MDS's residents would not receive one hundred percent (100%) of care needed.</p> <p>Observation of Resident #9 on 02/15/11 at 10:56am revealed the resident with an indwelling foley catheter to bedside drainage.</p> <p>Review of Resident #9's record revealed an admission date of 01/10/11 with a diagnosis of Cerebral Vascular Accident, Diabetes, Hypertension, Hyperlipidemia, Benign Prostatic Hyperplasia, Urinary Retention, Dysphagia, and Left sided Hemiplegia. The facility completed an admission Minimum Data Set (MDS) on 01/17/11 which revealed an indwelling foley catheter was in place. Resident Conference notes dated 01/28/11 included the indwelling foley catheter. However, a care plan had not been developed for catheter care which was thirty-one (31) days after admission.</p> <p>Interview with Registered Nurse (RN) #1 on 02/16/11 at 11:15am revealed that RN #1 was responsible for completing the MDS and developing care plans. The RN confirmed she had overlooked the catheter and failed to develop a plan of care. The RN stated that a care plan directs the care provided to the resident. Without a care plan on catheter care, the resident is placed at a risk for infection.</p>	F 279		



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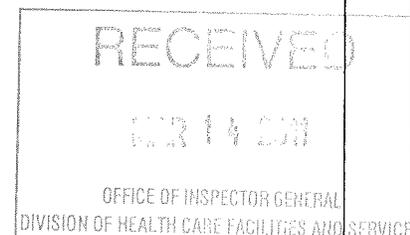
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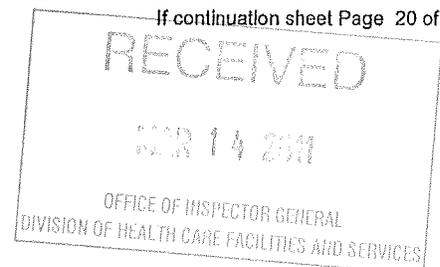
F 279	Continued From page 18 Interview with the Director of Nursing (DON) on 02/17/11 at 4:10pm revealed that the MDS coordinator is responsible for developing and updating the care plan. The DON confirmed that the care plan had not been completely developed and stated ultimate responsibility in ensuring the MDS coordinator creates a comprehensive plan of care.	F 279	F-309 Resident #1 order was clarified to support the L'nard Splint. Resident # 4 MAR was updated to discontinue the order. Resident #5 TED hose order was clarified	3/25/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow physician orders for three (3) residents of the sixteen (16) sampled residents (Resident's #1, #4, and #5). Resident #1's L'nard splint did not get applied as ordered, Resident #4's Medical Administration Record (MAR) was not updated to discontinue an order when a new order was obtained, and Resident #5's TED Hose did not get applied consistently to the lower extremities as ordered.  The findings include:  Review of the facility's Medication Administration Times Procedural Guidelines (MATPG) revealed medications orderd every day (QD) should be	F 309	All residents have the potential to be affected. The DHS or designee will audit current 30 day orders by using the Physician Order Audit Form (G) to ensure accurate transcription. All licensed staff will be inserviced on following physician orders on 3/11/11.  The DHS or her designee will ensure physician orders are being following by reviewing 4 charts per week for 4 weeks, 2 charts a week for 4 weeks and 1 chart per week for 4 weeks.  The chart audits will be reviewed monthly with the IDT during our QA meeting.	



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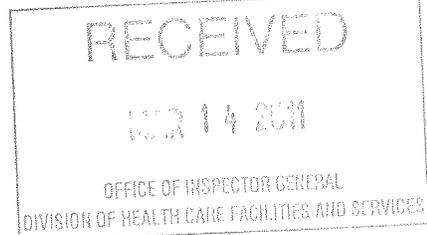
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/17/2011
NAME OF PROVIDER OR SUPPLIER  GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(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 309	<p>Continued From page 19</p> <p>administered after the resident awakens in the morning (morning is designated as between 4am and 10 am). MATPG revealed the physician should inform the admitting nurse if any of the the standing orders should be eliminated, modified and/or other standing orders added for the specific resident.</p> <p>Review of the clinical record for Resident #4 revealed that on 01/29/11 an order was written for Prilosec 20 mg. tab, give one (1) tablet orally twice a day. On 02/02/11 an order was written for Prilosec 20 mg. orally Q D. Review of Resident #4's MAR revealed the order written on 01/29/11 had not been discontinued when the order on 02/02/11 was written. Nursing staff had initialed the MAR since 01/29/11 that Resident #4 had received the morning and evening dose. The Nursing Staff had also initialed since 02/02/11 that another morning dose had been given. A count of the missing tablets in the blister pack revealed that the resident had been receiving the morning and evening dose as prescribed on 01/29/11, (the order that should have been discontinued). Resident #4 should have been receiving only one 20 mg. tablet every day as ordered on 02/02/11.</p> <p>Interview with the Registered Nurse (RN) #2, first shift Staff Nurse, on 02/16/11 at 3:50pm revealed that she was aware the order written on 01/29/11 should have been discontinued. The RN #2 stated the Prilosec is on the MAR double. She was uncertain why the order was not discontinued on the MAR when the frequency of the dose changed on the new order on 02/02/11. The Pharmacy initiates the MARS. She was not certain who should have checked the MAR. Someone comes in at the end of each month at night to check the orders on the MARS. She just</p>	F 309			



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F 309	<p>Continued From page 20</p> <p>gives the morning dose because she works first shift.</p> <p>Interview on 02/16/11 at 4:30pm with MDS RN #1 revealed that she was aware the order written on 01/29/11 should have been discontinued. MDS RN #1 said the doctor should have written an order to discontinue the order written on 01/29/11 when the new order was written on 02/02/11 changing the frequency of the dose.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, first shift staff nurse, on 02/17/11 at 10:25am revealed that she was aware when an order is given to change the frequency of the dose of a medication the old order should be discontinued, dated, and initialed. LPN #1 said this was a medication error and learned that years ago in Nursing School.</p> <p>Interview with Certified Medical Technician, (CMT) #1 second shift, on 02/17/11 at 3:10pm revealed 64 Prilosec tablets had been delivered on 01/29/11, 42 prilosec tablets were used and 22 tablets were left in the blister pack. The CMT #1 stated that confirms Resident #4 did receive the evening dose as well as the morning dose.</p> <p>Interview with the Director of Nursing (DON) on 02/17/11 at 4:50pm revealed Nursing Staff was not accurately documenting the services provided in accordance with current professional standards and practices. The DON stated any nurse should have known to discontinue original routine orders and to change the MAR. That was basic nursing. In addition the DON stated nurses know that if it was not documented it was not done and if it were documented it was done. Obviously they need to put some new systems in</p>	F 309			



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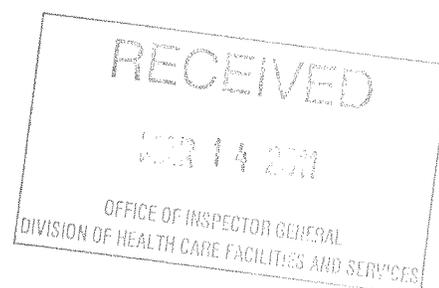
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F 309	<p>Continued From page 21 place.</p> <p>Observation of Resident #1 on 02/15/11 at 10:35am, 11:00am, 11:30am, 12:30pm, 1:25pm, 2:15pm 3:30pm, 4:15pm and 4:40pm revealed the resident was up in the wheel chair with no L'nard splint on the right leg. Further observation revealed on 02/15/11 at 4:50pm PTA #1 applied a L'nard splint to Resident #10's right leg.</p> <p>Review of the Minimum Data Set (MDS) revealed Resident #1 was re-admitted to the facility on 12/21/10 with diagnoses of A-Fib, Closed Fracture fibula with tibia, HTN, and CAD. Review of the physician order effective date 02/11/11 at 7:00am revealed L ' nard splint to right leg to relieve pressure. Further review of Resident #1's care plan revealed the L'nard splint update was on 02/11/11.</p> <p>Interview with PTA #1 on 02/15/11 at 5:00pm revealed that she was unsure of the date and time the order was received in the physical therapy department. She further revealed that her supervisor found the L'nard splint on 02/15/11 in the facility. Continued interview revealed that by not following the physician's order promptly there was a potential for further injury to Resident #1's right heel pressure wound.</p> <p>Interview with RN #3 on 02/16/11 at 2:30pm revealed that she received the physician's order on 02/11/11, unsure if she notified physical therapy by fax, or by just verbally notification. She further revealed that the registered nurse is responsible for ensuring the physician's order was followed.</p>	F 309			



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F 309	<p>Continued From page 22</p> <p>Interview with the DON on 02/17/11 at 4:00pm revealed that by not following the physician's orders promptly, there was a potential for further injury to Resident #1's right heel pressure wound.</p> <p>Observation of Resident #5 on 02/15/11 at 10:35am, 11:30am, 12:10pm, 2:10pm, 2:25pm, 3:30pm and 4:30pm revealed no TED hose on the lower extremities. Observation of Resident #5 on 02/16/11 at 8:15am, 10:30am, 11:30am, and 12:15pm revealed no TED hose on the lower extremities.</p> <p>Review of the MDS (Minimum Data Set) revealed Resident # 5 was admitted to the facility on 02/01/11 with a diagnosis of a right Hip Revision, Hypertension, Anemia and Pain. Review of the medical record for Resident #5 revealed physician progress note dated 02/12/11 states right leg with 2 plus edema noted. Further review of the record revealed that the physician order dated 02/12/11 at 3:00pm stated TED hose to both legs.</p> <p>Interview with RN #3 on 02/16/11 at 2:45pm revealed she received the physician order for TED hose for Resident #5. She further revealed that the TED hose order was not transferred to the treatment order form. Continued interview revealed that not following the physician's orders for four (4) days could have increased the resident's lower extremity edema.</p> <p>Interview with the DON on 02/17/11 at 4:00pm revealed that management staff from all departments had a morning meeting to review the past 24 hour physician's orders. She further stated that the MDS Coordinator was responsible for updates to the care plan. Continued interview</p>	F 309		



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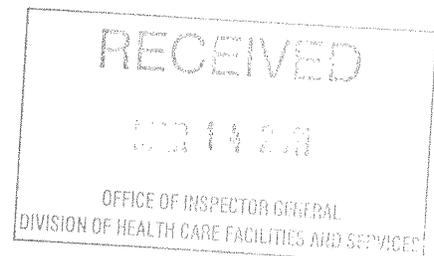
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F 309	Continued From page 23 revealed that the Assistant Director of Nursing (ADON) or DON performs quality checks on various charts periodically. She further stated that by not following the physician's orders promptly, there was a potential for increased edema, and impaired circulation to Resident #5.	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F-441  LPN #1 immediately washed her hands. LPN #1 was in serviced on our hand washing policy. CNA #2 was in serviced on our hand washing policy.  The DHS or her designee has observed skin treatments to ensure that infection control is being maintained. The DHS or her designees observe at least one meal room service per week to determine infection control is being followed (I).  The DHS or her designee will observe at least 1 treatment per week for 4 weeks The ADHS will observe at least one room service meal per week for 4 weeks (H).  The audits will be reviewed by the IDT monthly during our QA meeting.	3/25/11



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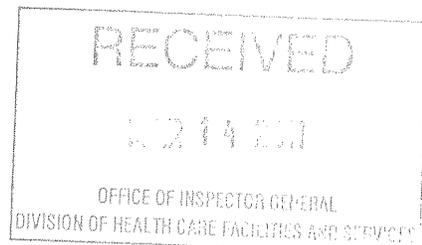
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F 441	<p>Continued From page 24</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure proper infection control practices were maintained by staff not sanitizing hands during wound care when changing gloves and using bare hand contact with food during meal pass.</p> <p>The findings include:</p> <p>Review of facility policy titled Hand Washing dated 2009 revealed that employees will use proper hand washing techniques to prevent the spread of infection. Staff should use alcohol-based hand rub containing 60-95% ethanol or isopropanol after the removal of gloves.</p> <p>Observation of Resident #1 on 02/15/11 at 12:00pm, revealed LPN#1 performed wound care on Resident #1's right lower heel. LPN#1 removed the old dressing, applied a new pair of clean gloves, cleaned the right heel area with soap and water then placed another pair of clean gloves on. Then the LPN applied betadine to the wound area, changed gloves and proceeded to wrap the right heel with a clean dry dressing. LPN #1 did not sanitize hands during the clean glove changes.</p>	F 441		



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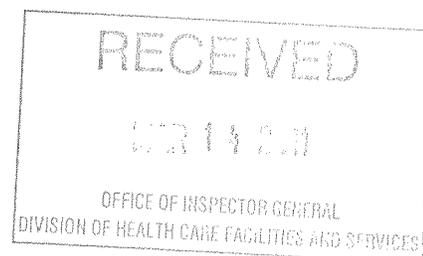
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F 441	Continued From page 25  Interview with LPN #1, on 02/15/11 at 3:00pm, revealed she had been trained in infection control. She further revealed hand sanitation should be used between glove changes to prevent cross contamination.  Interview with the Assistant Director of Health Services (ADHS) on 2/17/11 at 3:30pm revealed she worked at the facility for three (3) years. She became the ADHS in April 2010. She further stated she was responsible for in-service training. The staff should sanitize hands between glove changes to prevent cross contamination.  Observation of the lunch tray pass on halls 100, 200, and 300 on 02/16/11 at 12:00pm, revealed the Certified Nursing Assistant (CNA) #2 delivered a lunch tray to Resident #12, and while delivering the tray, she adjusted the overbed table. The CNA did not sanitize or wash her hands before delivering a lunch tray to Resident #2. While in this resident's room the CNA adjusted the resident's overbed table and call light. While cutting the resident's chicken tenders, she held the chicken with her bare hands, and cut it with a knife. Before the CNA left the resident's room she stroked the resident's hair. The CNA then proceeded to deliver other lunch trays without sanitizing or washing her hands.  Interview with CNA #2 on 02/16/11 at 12:20pm, revealed she had worked at the facility for seven months. When asked how she normally performs tray pass she stated she knows she forgot to sanitize her hands between each tray, as she was taught. When asked about touching, Resident #2's chicken tenders, she stated her hand slipped	F 441		



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F 441	Continued From page 26 as she was cutting them up for the resident. She stated she has heard before that she is not supposed to touch residents' food with bare hands. She gave no explanation for not sanitizing or washing her hands. The CNA acknowledged that germs could be spread by not washing or sanitizing her hands and then touching a resident's food. She stated this practice could lead to infections or illness. She stated she remembered some training in orientation regarding this, but did not remember attending an inservice on this topic since then.  Interview with the Assistant Director of Health Services (ADHS) stated she had worked at the facility for three years. She became the ADHS in April 2010. She stated she was responsible for inservice training. She stated that all staff in orientation have training on fine dining and they are inserviced annually on it. The last inservice for fine dining was in December 2010. The staff are taught not to touch food with bare hands at all. They are also taught to sanitize or wash their hands between each tray when passing trays to residents. If a staff person misses an inservice, that employee is given the information and signs to show that he or she had received it.	F 441			



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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 02/16/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "E".	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. This deficiency has the potential to affect two (2) of eight (8) smoke compartments and approximately twenty-five (25) residents, staff and visitors. The facility has the capacity of seventy (70) beds with a census of sixty five (65) at the time of the survey.  The findings include:  Observation on 02/16/2011 at 10:30 AM, revealed mini-blinds installed on the exit door located at the end of the corridor, near rooms 520 and 521. The mini-blinds could be an impediment to the operation of the door or cause confusion in case of fire or other emergency. This observation was confirmed with the Administrator and the Maintenance Director.	K 038	<b>K 038</b>  The blinds on the exit door located at the end of the corridor near rooms 520 and 521 were immediately removed.  The residents who reside on the 500 hall are affected by this deficient practice.  The Executive Director will ensure that blinds will not be installed on any of the campus exit doors.  The Executive Director will ensure that blinds will not be installed on any of the campus exit doors and will verify this during weekly rounds with the Director of Plant Operations.	3/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *3/11/11*

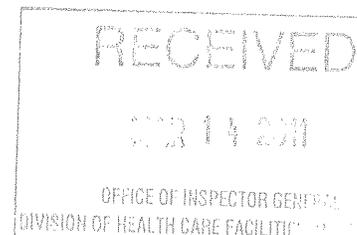
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES

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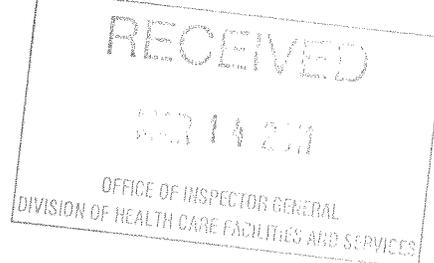
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K 038	Continued From page 1  Interview on 02/16/2011 at 10:30 AM with the Administrator and the Maintenance Director revealed they did not know they could not use mini-blinds on the door.  Reference: 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency has the potential to affect three (3) of eight (8) smoke compartments, approximately thirty-five (35) residents, staff and visitors. The facility is licensed for seventy (70) beds and the census on the day of the survey was sixty five (65).  The findings include:  Observation on 02/16/2011 at 9:55 AM revealed hanging decorations on doors to resident rooms 112, 205, 303 and 305. The Administrator and the Maintenance Director indicated they were not aware of the requirement to treat decorations with a fire retardant spray and keep record for documentation.	K 038	K 073  Director of Plant Operations (DPO) logged and treated current door and room decorations with fire retardant spray.  Residents who have door and room decorations have the potential to be affected by this deficient practice.  The DPO will spray any new items that are brought into the campus for resident room and door decorations with fire retardant spray and log that these items have been sprayed. This is logged on the Door and Room Decoratin Log (A).  The DPO will check resident rooms monthly to verify if any new items have been brought into the campus that have not been sprayed with fire retardant spray. Any new items will be sprayed and documented on the log. This will be brought to the monthly QA meeting and reviewed by the IDT.	3/25/11	



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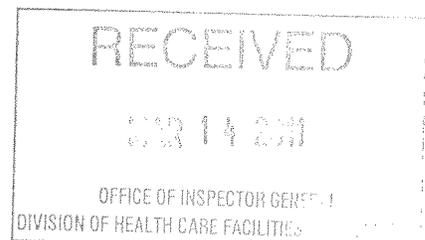
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 073	Continued From page 2	K 073		
K 141 SS=D	<p>Interview with the Administrator and Maintenance Director on 02/16/2011 at 9:55 AM, indicated they did not have a written policy for treating the decorations and would implement a policy for documentation.</p> <p>Reference : NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 18.3.2.4, NFPA 99, 8.6.4.2.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the rooms where oxygen cylinders were stored had proper signage as required.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour conducted on 02/16/2011 at 9:55 AM revealed a crash cart with oxygen stored in the Med Prep room. No signs were displayed at the entrance of the door indicating oxygen storage in that room.</p> <p>Interview with the Maintenance Director and the Administrator on 02/16/2011 at 9:55 AM, revealed the Maintenance Director and the Administrator were unaware that the room needed a sign.</p>	K 141	<p><b>K 141</b></p> <p>An oxygen sign was immediately posted on the door of the Med Prep room.</p> <p>All rooms storing oxygen have the potential to be affected by this deficient practice.</p> <p>The Director of Plant Operations will include in his PM rounding to check all areas that store oxygen have an oxygen sign on the door.</p> <p>The DPO will check rooms that store oxygen and ensure a sign is on the door. This will be checked weekly during PM rounding (B) . The check list will be brought to the monthly QA meeting and reviewed by the Interdisciplinary team.</p>	3/25/11



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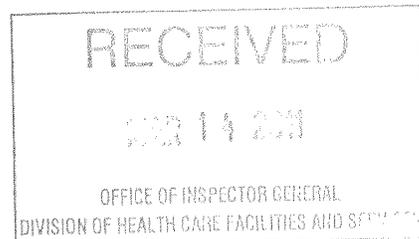
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K 141	Continued From page 3	K 141		
K 147 SS=E	<p>NFPA: 99, 1999</p> <p>8-6.4.1.7 All labeling shall be durable and withstand cleansing or disinfection.</p> <p>8-6.4.2* Signs. Precautionary signs, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected three (3) of eight (8) smoke compartments, staff, visitors and approximately twenty-eight (28) residents. The facility has the capacity for seventy (70) beds with a census of sixty-five (65) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 02/16/11, with the Director of</p>	K 147	<p>K 147</p> <p>The items stored by the electrical panel in the kitchen, solid utility room, CSR Office and DPO office were moved to another location. An approved cover was placed on the junction box on the powered roof vent. The light fixture located in the janitor's closet in the laundry room had an approved cover placed on it.</p> <p>The DPO checked all areas of access to electrical panel boxes in the campus and verified that they were clear of storage and obstacles. All light fixtures were checked and verified that they had approved covers in place. All junction boxes used for powered fans, etc. were checked and verified to have approved covers.</p>	3/25/11



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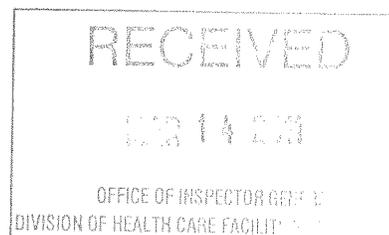
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K 147	<p>Continued From page 4</p> <p>Maintenance and the Administrator revealed:</p> <p>(1) The facility failed to ensure that access to the electrical panels located in the kitchen, soiled utility across from the Health Club, Computer Service Rep Office, and the Maintenance Directors office, were free of storage and obstructions.</p> <p>(2) Junction box on powered roof vent, located in the attic, did not have an approved cover.</p> <p>(3) The light fixture located in the janitors closet, in the laundry area did not have an approved cover.</p> <p>Interview on 02/16/11, with the Director of Maintenance and the Administrator revealed:</p> <p>(1) The Director of Maintenance and the Administrator were unclear about the clearances, involving electrical panels.</p> <p>(2) The Director of Maintenance was not sure how the cover came off of the junction box, but would replace the cover.</p> <p>(3) The Director of Maintenance was unsure of what happened to the cover on the light fixture.</p> <p>(1) Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and</p>	K 147	<p>The DPO updated his PM rounding (B) to include checking areas of access to electrical panels to be free of storage and obstacles, ensure all light fixtures have approved covers and that all junction boxes used for powered fans, etc. have approved covers in place.</p> <p>The DPO will check weekly using his PM rounding tool areas of access to electrical panels to be free from storage and obstacles, ensure all light fixtures have approved covers in place, and that all junction boxes used for powered fans, etc. have approved covers in place. The checklist will be brought to the monthly QI meeting and discussed with the IDT.</p>		



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K 147	<p>Continued From page 5</p> <p>maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(2) Reference: NFPA 70 (1999 edition) 370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>(3) Reference NFPA 70 (1999 Edition) (A) Definition.</p> <p>Figure 410.8 Closet storage space. (B) Luminaire (Fixture) Types Permitted. Listed luminaires (fixtures) of the following types shall be permitted to be installed in a closet: (1) A surface-mounted or recessed incandescent luminaire (fixture) with a completely enclosed lamp (2) A surface-mounted or recessed fluorescent luminaire (fixture) (C) Luminaire (Fixture) Types Not Permitted. Incandescent luminaires (fixtures) with open or partially enclosed lamps and pendant luminaires (fixtures) or lampholders shall not be permitted.</p>	K 147		



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K 147	Continued From page 6 (D) Location. Luminaires (fixtures) in clothes closets shall be permitted to be installed as follows: (1) Surface-mounted incandescent luminaires (fixtures) installed on the wall above the door or on the ceiling, provided there is a minimum clearance of 300 mm (12 in.) between the luminaire (fixture) and the nearest point of a storage space (2) Surface-mounted fluorescent luminaires (fixtures) installed on the wall above the door or on the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space (3) Recessed incandescent luminaires (fixtures) with a completely enclosed lamp installed in the wall or the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space (4) Recessed fluorescent luminaires (fixtures) installed in the wall or the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space	K 147		

