

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Corrective Action for styrofoam cups: Styrofoam cups will not be used regularly except for emergency or isolation purposes. Other patients potentially affected: All patients with p.o. intake have the potential to be affected.	7/16/10
F 241 SS=C	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observation and interview, it was determined the facility failed to promote care for residents in a manner and environment that maintained dignity, respect and individuality. A review of the Census and Conditions form, dated 06/22/10, revealed the facility census was 58. It was determined 56 of 58 residents were served food that was prepared and served from the facility kitchen. The facility served the residents food in Styrofoam cups, that normally would be served in a bowl. For example, salads were served in the Styrofoam cups. Italian Dressing was drizzled over every salad, without first offering the residents a choice of salad dressing. Finding include: An observation of the tray-line, on 06/22/10 at 12:00 PM, revealed the cook served tossed salads in half-filled, eight (8) ounce Styrofoam cups. A large bottle of Italian Dressing was used to drizzle approximately "two-tablespoons full" of	F 241	Systemic changes: New 4 ounce and eight ounce bowls and lids were ordered on 6/22/10 from Gordon food services. Items delivered and put into use on 6/30/10. 6/28/10 dietary staff were inserviced by dietary manager that beginning immediately the new bowls and lids would be used in place of styrofoam with the exception of emergencies or isolation. Performance Monitoring: To monitor performance, dietary manager will maintain an inventory of styrofoam products updated monthly. This inventory reconciliation is used to ensure all styrofoam products have only been used for identifiable emergencies or isolation purposes. Corrective Action for salad dressing: Patients will be given a choice of salad dressing. Resident council and interviewable patients were interviewed by the dietary manager on 7/13/10 in order to determine patient preferences for salad dressing. Other patients potentially affected: All patients with p.o. intake have the potential to be affected.	

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

TITLE

(X6) DATE

Jennifer A. ...

Administrator 7/14/10

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.

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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	<p>Continued From page 1 dressing onto each salad.</p> <p>An observation of the tray-line, on 06/23/10 at 11:30 AM, revealed a Bacon, Lettuce and Tomato (BLT) Salad was served as the entree for lunch on plates. However, Italian Dressing was used on all the salads.</p> <p>Interviews with two alert and oriented residents, (#16 and #17), on 06/22/10 at approximately 12:30 PM, revealed salads were always served with Italian Dressing and a choice of dressing was never offered. Items such as beans, salad and any food that would normally be served in a bowl, was served in a small Styrofoam cup.</p> <p>An interview with Cook #1, on 06/23/10 at 11:40 AM, revealed the use of the Styrofoam cups was requested by the dietician.</p> <p>An interview with the dietician, on 06/24/10 at 10:42 AM, revealed she had instructed the staff to use eight (8) ounce Styrofoam cups to determine the salad serving size. The staff had previously used a dessert cup for salads, which was not a large enough serving. The dietician stated she was unaware dietary staff used Styrofoam cups for beans, vegetables and salads.</p>	F 241	<p>Systemic changes: Individual preferences will be honored by providing a variety of individual packets of salad dressing to be offered as a choice at the time salad is served. Monitoring performance: Dietary Manager will meet with resident council monthly and prn to ensure patient choices are honored and to determine if there are any new requests.</p> <p style="text-align: right;">7/28/10</p>
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to</p>	F 281	<p>Corrective action for patient #4: a miscellaneous flow sheet was initiated 6/22/10 for GU irrigation that recorded the amount of irrigation infused every shift. The miscellaneous flow sheet also recorded the date and time a new bag was hung, calculated urinary output, the amount of GU irrigation left hanging at the end of the shift and the nurse's initials.</p>

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 281	<p>Continued From page 2</p> <p>ensure services provided by the facility met professional standards for one resident (#4), in the selected sample of 15, related to the failure to follow physician's orders.</p> <p>Resident #4 had an order for a bladder irrigation to be administered continuously. The facility failed to ensure the order was followed consistently. Additionally, the facility failed to ensure a physician's order was transcribed correctly and the medication was administered by a different route than specified in the order.</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility with diagnoses to include Traumatic Subdural Hematoma, Coma and Neurogenic Bladder and was identified as in a persistent vegetative state. A review of the Minimum Data Set (MDS) assessment, dated 05/10/10, revealed Resident #4 was totally dependent on staff for all care.</p> <p>An observation, on 06/22/10 at approximately 11:00 AM, revealed Resident #4 was transferred to bed by two Certified Nurse Aides (CNAs), using a mechanical lift. A bag of Genitourinary (GU) irrigant, containing 400 cubic centimeters (cc) was hanging near the foot of the bed and was not infusing. Further observations, at 12:30 PM, 3:40 PM and 4:30 PM, revealed the GU irrigant was not infusing and contained 400 cc of irrigant.</p> <p>An interview with RN #1, on 06/22/10 at approximately 4:30 PM, revealed the GU irrigant was turned off at approximately 10:30 AM, when Resident #4 was transported to the whirlpool bath and was not restarted, when the resident was transferred back to bed. The GU irrigant had</p>	F 281	<p>The licensed nurses were educated regarding the continuous bladder irrigation policy and procedure for GU irrigation and the miscellaneous flow sheet requirements on 6/22/10.</p> <p>Other patients potentially affected are those requiring GU irrigation.</p> <p>Systemic changes: The GU irrigation policy and procedure has been revised and approved by the Medical Director. The policy and procedure includes a flow sheet specific for GU irrigation. The flow sheet will be completed every shift and will reflect the amount of irrigation infused for each shift and the amount of irrigation left hanging at the end of the shift. The new policy has been posted for all licensed nurses to read and initial as understanding prior to working their next shift.</p> <p>The policy and procedure will be discussed in more detail on 7/28/10 during a nursing inservice.</p> <p>Performance monitoring: The licensed nurses at change of shift will check for policy compliance. Additionally, the RN will check daily for policy compliance as evidenced by completion of the GU irrigation flow sheet for three months then weekly and prn. Any noncompliance with the policy will be reported to the DON, Administrator or designee.</p>		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 281	<p>Continued From page 3</p> <p>been off for approximately six hours. RN #1 stated it was her responsibility to ensure the GU irrigant was administered as ordered and she had overlooked it and did not ensure it was infusing on return from the whirlpool.</p> <p>An interview with the Director of Nursing (DON), on 06/22/10 at approximately 6:00 PM, revealed the GU irrigant should not be turned off during a whirlpool bath, because the physician's order was for continuous administration of the irrigant. The DON stated there would be a risk of obstruction if the irrigant was not administered continuously.</p> <p>A review of the physician's orders, dated 06/01-30/10, revealed the order, "Neomy-Polymyxin B 40 milligrams (mg)/Neosporin GU irrigant per 1000 cc of Normal Saline continuous".</p> <p>A review of the facility's undated policy and procedure, for bladder irrigation, (page 605), revealed "Interruptions in a continuous irrigation system can predispose the patient to infection".</p> <p>Further record review revealed Resident #4 was admitted to the hospital, on 01/23/10, with a diagnoses of Bilateral Gram Negative Pneumonia and returned to the facility, on 02/27/10, with a physician's order dated, 02/27/10, for "Tobramycin 300 mg IV solution every 12 hours per nebulizer". However, the transcribed order, dated, 02/27/10, revealed "Tobramycin 300 mg IV every 12 hours times 21 days".</p> <p>A review of the Medication Administration Records (MAR), dated February 2010 and March 2010, revealed Resident #4 received Tobramycin 300 mg IV, from 02/27/10 through 03/03/10, two</p>	F 281	<p>Corrective action for transcription error: The transcription error was noted on 3/4/10 at which time the attending physician, the Medical Director and the patient's family were notified. The Tobramycin was discontinued on 3/4/10 per physician's orders.</p> <p>Other patient's potentially affected are those with physician's orders upon admission or readmission to the facility.</p> <p>A systemic change was implemented on 3/4/10 and comprised of not only the transcribed facility admission orders but also the discharging facilities orders are faxed to the pharmacy. The pharmacy performs a second transcription accuracy check and contacts the facility for any clarifications. A third transcription accuracy check is performed by the licensed nurse receiving the printed physician orders with the MAR from the pharmacy. A fourth transcription accuracy check is performed by the RN during admission audits. All transcription errors are corrected immediately and reported to the DON, Administrator or designee.</p>		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 281	Continued From page 4 times a day, for a total of five days. A review of the nursing notes, dated 03/04/10 at 7:10 AM, revealed documentation included, "IV Tobramycin should have been via nebulizer treatments as noted on the 02/27/10 hospital orders". An interview with the DON, on 06/23/10 at approximately 11:30 AM, revealed RN #2 did not transcribe the physician's order correctly onto the MAR and signed it off. An interview with RN # 2, on 06/24/10 at approximately 3:00 PM, revealed she transcribed the order for the Tobramycin incorrectly. She stated she did not notice the part of the order that indicated it was to be administered via nebulizer treatment.	F 281		7/28/10	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record reviews, it was determined the facility failed to ensure each resident received adequate supervision and assistance for two residents (#5 and #9), in the selected sample of 15. The facility failed to ensure Resident #9 did not possess over the counter and/or narcotics at the	F 323	Corrective action for patient #9: a room search was completed on 6/25/10 and all OTC products, as well as spices or creams the patient was using to self medicate or treat were removed from the patient's room. The patient's responsible party and patient were educated regarding not leaving these products in the patient's room. Physician's orders were obtained for the continued use of the products while under supervision. The products are stored in the medication room or the medication cart. The patient's care plan was updated and the patient's room has been searched on a daily basis; no additional products have been present. Systemic changes: Weekly room checks will be performed in all patients' rooms. When products with the potential for misuse are		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5 bedside.</p> <p>The facility failed to ensure adequate supervision for Resident #5, in accordance with care plan interventions. Resident sustained multiple unobserved falls from a wheelchair. Findings include:</p> <p>1. Resident #9 was admitted to the facility with diagnoses to include Dementia, Coronary Artery Disease, Hypothyroidism, Anxiety and Depression. A review of the Minimum Data Set (MDS), dated 01/29/10, revealed Resident #9 was assessed as cognitively impaired and exhibited behaviors which included resisting care, verbal and physical abuse. Resident #9 was seen by Psychiatric Services monthly.</p> <p>An observation, on 06/24/10 at approximately 3:50 PM, revealed Resident #9 was socializing with other residents in the dining room and exhibited a friendly demeanor.</p> <p>A review of a nursing note, dated 04/12/10 at 3:30 PM, revealed "several Bactrim (antibiotic), a bottle of Asprin and one yellow pill removed from patient's room today". A nursing note, dated 05/24/10 at 5:10 PM, revealed "Aid reported to Social Services that patient had medicine in room in purse. Social Services brought this nurse prescription bottles containing Lomotil (antidiarrhea), Ambien (sleeping pill), Periactin (antihistamine), Valium (tranquillizer), Lanoxin (heart medication) and Tylenol. A review of the physician's progress note, dated 04/12/10, revealed "Resident found with prescription medications".</p> <p>An interview with Licensed Practical Nurse # 1, on</p>	F 323	<p>found, the products will be remove and the patient's physician and responsible party will be notified. If the physician deems the products benign and safe for the patient to keep at the bedside an order will be written and the patient's care plan updated. If the physician does not approve the products be left at the bedside, daily room checks will be performed until adherence to policy is demonstrated consistently.</p> <p>Performance monitoring: Weekly and daily compliance checklists will be reviewed at least monthly by the safety committee. The safety committee will ensure compliance with room checks and report findings to the QA committee.</p> <p>Corrective action for patient #5: The patient's care plan was updated to create a realistic intervention. The patient is capable of propelling herself while up in the wheelchair and it is unrealistic to expect her to sit at the nurses' station or for the patient to have one:one constant supervision while up in the wheelchair. The intervention was updated to encourage the patient to be out or her room while up in the wheelchair. The licensed nurse who wrote the intervention was educated by the DON on 6/24/10 regarding appropriate interventions for safety.</p> <p>Any patient assessed for high fall risk may be affected by this practice in the future.</p>		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	<p>Continued From page 6</p> <p>06/25/10 at approximately 2:10 PM, revealed Resident #9 had multiple prescription medications in his/her possession, on 05/24/10. LPN #1 stated the medications were removed from the resident's possession and narcotic sheets were created for the accounting of the controlled substances. A family member came to the facility the next day and took possession of the drugs. LPN #1 stated she reported the incident to the on-coming staff/shift, but did not report the incident to the Director of Nursing (DON) or the resident's physician. LPN #1 stated the resident had left the facility with family members and had gone to the resident's home, on occasion prior to returning to the facility. LPN #1 felt the resident might have obtained the prescription medications during an outing and brought the medications back to the facility.</p> <p>An interview with the DON, on 06/25/10 at approximately 2:30 PM, revealed she was not aware the resident had possession of the prescription medications and should have been informed. The DON stated an investigation should have been conducted and the resident's care plan should have been revised to address the problem. On 06/25/10 at approximately 3:15 PM, after surveyor inquiry, Resident #9's room was searched and two bottles of Alum, a jar of Soltice Quick Rub, a bottle of Neet hair remover, a container of Peroximent (oral care agent), Triamcinolone Acetonide 0.1% dental paste and a pair of scissors were found and removed from the resident's room.</p> <p>An interview with Resident #9, on 06/25/10 at approximately 3:40 PM, revealed the resident was hard of hearing and made no eye contact during the conversation. Resident #9 stated he/she did</p>	F 323	<p>Systemic changes: All nursing staff will be educated regarding fall interventions. Included in that education will be what to do if the written intervention is not effective, relevant, or appropriate for that specific patient. The following performance monitoring and ongoing QA process plays a large role in the systemic change to ensure adherence to care plans by adding staff interviews, care plan reviews, and patient/staff observation by the DON or designee. Performance monitoring: As part of the QA process the DON or designee will investigate through staff interview, care plan review, observation, etc. the appropriateness of fall interventions for those patients with frequent falls. The quarterly QA safety reports regarding falls will be expanded to include staff compliance with fall intervention education and care plan adherence.</p>	

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	<p>Continued From page 7</p> <p>not know anything about any medicines other than a Niacin tablet, which was administered by staff for "Arthritis".</p> <p>A review of the facility's policy and procedure entitled, "Pharmacy Services", dated 04/17/09 and revised 12/29/09, revealed under the "Storage" section as follows:</p> <p>"No medication will be kept at the bedside unless the patient's physician approves as evidenced by an order and care planned by the interdisciplinary care plan team. Medications brought into the facility by the patient or responsible party should be returned to them and not kept at the facility. There may be instances when medications are left in the facility or found by the staff in the patient room. The medication, including OTC or prescription medications, will be removed from the room and placed in the medication room and labeled with the patient's name until they can be returned to the responsible party."</p> <p>2. Resident #5 was admitted to the facility with diagnoses to include Weakness, Dementia, Anxiety, Cardiomegaly and Kyphosis. A review of the MDS assessment, dated 06/15/10, revealed the facility identified the resident as alert, oriented to person with confusion and exhibited behaviors of being combative with care at times and removing the safety alarm from his/her bed and wheel chair and getting up at times unassisted.</p> <p>An observation, on 06/22/10 at approximately 11:00 AM, revealed Resident #5 was seated in a small size wheelchair with an alarm clipped to the resident's clothing. The resident (eyes closed) rested his/her head on the arm rest.</p>	F 323			

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	Continued From page 8 A review of the initial Fall Risk Assessment, dated 03/13/10, revealed the facility identified Resident #5 as at high risk for falls. Review of the care plan for the problem, "At risk for falls" dated, 03/2010, revealed interventions including the use of bed and wheelchair alarms, and was "not to be alone while up in wheelchair". Further review of the care plan revealed Resident #5 had experienced 13 falls, during the period of 03/13/10 through 06/23/10, with various revisions to the interventions. A review of the Incident/Accident report, dated 03/13/10 at 2:00 PM, revealed Resident #5 was found lying on the floor in front of his/her wheel chair. The fall was "unobserved". A revision to the care plan interventions included a tab alarm and the resident was not to be left in his/her room unattended while up in the wheelchair. However, the report revealed Resident #5 was found, on the floor of the resident's room at 5:00 PM. The fall was identified as "unobserved". A review of the Incident/Accident report, dated 04/27/10 at 4:00 PM, revealed Resident #5 was observed crawling on hands and knees on the East Hall floor. The resident stated he/she got out of the wheelchair to go to the bathroom. The incident was identified as "unobserved". A review of the Incident/Accident report, dated 5/24/10 at 2:30 PM, revealed Resident #5 was found on the floor in his/her room. The resident told staff he/she "slid out of the wheelchair onto the floor". The incident was identified as "unobserved". An interview with the MDS Coordinator, on 06/23/10, revealed any nurse could implement an	F 323			

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	Continued From page 9 intervention after a fall, to prevent another occurrence. The interventions were reviewed by the Fall Committee and changes or recommendations might be made at that time. Interventions included the supervision for Resident #5. Staff were not to leave Resident #5 unattended, when the resident was up in the wheelchair. There was no explanation provided regarding the lack of supervision during falls, which occurred, on 03/13/10, 04/27/10 and 05/24/10. Interviews were conducted with Certified Nurse Aides (CNA) # 1, #2, #3 and #4, on 06/24/10 at 2:50 PM, 3:00 PM, 3:30 PM and 3:35 PM, respectively revealed the aides were assigned to care for and provide supervision for Resident #5. The CNAs stated they were aware of the intervention to provide supervision and to not leave the resident alone in a wheelchair, but gave no explanation for the unobserved falls.	F 323		7/28/10	
F 371 SS=F	483.35(i) 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 and record review, it was determined the facility failed to	F 371	Corrective Action for inadequate food temperatures: 6/28/10 the dietary manager educated the dietary staff on the correct times for taking tray temperatures. All patients with p.o. intake have the potential to be affected by this practice. Systemic changes: the policy and procedure was revised. The new temperature recording sheet now includes a category for recording the time the tray temperature was obtained. Dietary staff were educated on 7/13/10 regarding the new policy and documentation requirements. Performance monitoring: The dietary manager or designee will monitor the temperature sheets and the RD will monitor the		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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	<p>Continued From page 10</p> <p>store, prepare and serve food under sanitary conditions, related to inadequate food temperatures, lack of calibration of thermometers and maintaining proper sanitation.</p> <p>A review of the Census and Conditions form, dated 06/22/10, revealed the facility census was 58. It was determined 56 of 58 residents were served food that was stored and prepared in the facility kitchen.</p> <p>Finding include:</p> <p>1. Observations, on 06/22/10 at 12:00 PM, on 06/22/10 at 5:10 PM and on 06/23/10 at 11:30 PM, of the tray line service, revealed the following test temperatures:</p> <p>Spaghetti, 128 degrees Fahrenheit (F) Barbecued chicken, 122 degrees F Tomatoes, 68 degrees F Deviled eggs, 48.2 degrees F</p> <p>Each of the food items had been tested and identified within the required ranges by the dietary staff, prior to the test temperatures obtained by the surveyor. Observation and interview with the dietary staff revealed staff had obtained the temperatures, 30 to 35 minutes, prior to the start of the tray-line. The time lapse between the temperatures and the service, allowed time for the food to change from the required ranges.</p> <p>An interview with Cook #2 on 06/22/10 at 12:05 PM revealed the digital thermometer used by the facility had not been calibrated.</p> <p>An interview with the Dietary Manager, on 06/23/10 at 12:05 PM, revealed she was not aware the dietary staff were taking food</p>	F 371	<p>sheets monthly for policy compliance. Corrective action for thermometer calibration: 6/28/10, dietary manager educated staff on proper calibration requirements for the thermometer. All patients with p.o. intake have the potential to be affected by this practice. Systemic changes: A new infrared thermometer was put into use starting 7/13/10. 7/13/10, the dietary staff were educated regarding the correct use of the infrared thermometer and return demonstrated proficiency. In accordance with policy, two back-up thermometers are available at all times. 7/13/10, dietary staff were educated on manual back-up thermometers with staff return demonstrating proficiency in calibration and appropriate utilization of manual back-up thermometers.</p> <p>Performance monitoring: The dietary manager or designee will perform monthly thermometer checks per manufactures recommendations to ensure they are working properly. All monitoring will be documented by dietary manager or designee and reviewed by the RD monthly for compliance. Monthly staff inservices will include return demonstration of thermometer proficiency.</p>		

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 11
temperatures 30 to 35 minutes prior to serving the meals and thermometers had not been calibrated.

2. An observation, on 06/23/10 at 11:50 AM, revealed the sanitizer bucket, used for cleaning the work surfaces, on the stove, counters and tray-line areas, tested with greater than 200 PPM of bleach solution.

An interview with the Dietary Manager, on 06/23/10 at 12:00 PM, revealed no posted or specific formula was available for the dietary staff to follow in order to obtain a correct solution for the most effective germ fighting and cleaning.

3. Observations, on 06/22/10 at 10:50 AM and on 06/23/10 at 11:00 AM, revealed the multi-compartment cooler/refrigerator tested at 44 to 46 degrees F. According to the health inspection report, dated 03/18/10, the problem had been identified and cited.

An interview with the Dietary Manager, on 06/23/10 at 11:05 AM, revealed the cooler had been used in the facility since the facility was built and "just was not functioning like it used to do."

F 463 483.70(f) RESIDENT CALL SYSTEM - SS=F ROOMS/TOILET/BATH

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, it was

F 371 Corrective action for proper sanitation: 6/28/10 the dietary manager posted a specific formula for proper water sanitation in the kitchen for all staff. Additionally the staff was inserviced on the posting. All patients have the potential to be affected by this practice. Systemic changes: the policy was updated and staff was inserviced on 7/13/10 regarding the proper use of available test strips which determine correct sanitation range. The dietary staff return demonstrated proficiency in mixing and testing sanitation water.

Performance Monitoring: The dietary manager will randomly test the sanitation water a minimum of three times a month, record results and require additional return demonstration as needed.

Corrective action for cooler temperature: 6/23/10 the heating and cooling professional serviced the cooler by adding Freon, bringing the cooler temperature into the correct range. 6/28/10 the dietary manager inserviced staff regarding the importance of reporting immediately to the dietary manager or the heating and cooling professional any cooler temperature greater than 41 degrees. All patients have the potential to be affected by this practice. Systemic changes: policy will be updated and staff will be educated 7/28/10 on the specific procedures to follow if the temperature is greater than 41 degrees.

F 463

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 463	Continued From page 12 determined the facility failed to ensure the nurses' station was equipped to receive resident calls through a communication system from toilet and bath facilities. The emergency call system was nonfunctional in nineteen (19) of twenty-four (24) resident bathrooms and one (1) of two (2) shower rooms. Findings include: An observation of the emergency call light system, on 06/22/10 at 11:30 AM, revealed eleven (11) of twelve (12) emergency call lights on the 300 wing of the facility were nonfunctional. When the emergency lights were activated in the resident bathrooms of rooms #301-#311, they did not light up above the doors or at the emergency panel located at the nurses' station. An interview, on 06/22/10 at 11:30 AM, with Licensed Practical Nurse (LPN) #1 assigned to the 300 wing on 06/22/10, revealed when the emergency lights were activated in the resident bathrooms, the lights above the door should light up in red to alert the staff it was the bathroom emergency light, which was activated. Additionally, the call light panel at the nurses' station should also light up. LPN #1 checked all emergency lights on the 300 wing and reported that only one functioned in the bathroom of room #312. The emergency bathroom call lights for Rooms #301-#311 were not functional, when checked by LPN #1 and the surveyor. An observation of all emergency call lights, on 06/22/10 at 3:55 PM, by the Environmental Services Director and the surveyor revealed 19 of 24 bathroom emergency call lights were nonfunctional throughout the facility and one of two shower room emergency call lights was nonfunctional. When activated, the emergency	F 463	In addition, the heating and cooling professional will increase servicing the cooler from approximately every six months to monthly. Performance monitoring: dietary manager will review temperature records weekly to ensure staff compliance with policies. RD will review the records monthly. F 463 Corrective action: Bells were purchased and secured to the call light cords in the non functioning patients' bathrooms. Additional bells were purchased for use if necessary. Patients who are able to call for assistance by using a call light were able to return demonstrate the use of the call bell. Additionally, a list of all affected rooms was posted for the nursing staff in various locations. Any patient with the ability to use the call light system has the potential to be affected by this practice. Systemic changes: The entire call light system is being replaced. Room call light and bathroom call light systems will be checked weekly for proper working order. These checks will be documented. Environmental services staff were inserviced on 7/13/10 regarding immediately reporting nonfunctional call lights. All nursing staff will be inserviced by 7/28/10.	7/28/10	

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

PRINTED: 07/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 463	<p>Continued From page 13</p> <p>lights neither alerted staff of a resident needing assistance by lighting up in red above the resident's bedroom door or by lighting up the call light panel at the nurses' station.</p> <p>An interview with the Environmental Services Director, on 06/22/10 at 3:55 PM, revealed she was unaware of any policy and procedure to ensure maintenance of the emergency call light system. She stated she periodically checked the bedside call light system, but she had not checked the emergency bathroom or shower room call lights and had no idea when the system had last been evaluated for functional status.</p> <p>An interview with the Director of Nursing (DON), on 06/22/10 at 4:30 PM, revealed she was unaware of any policy and procedure to ensure the emergency call light system was evaluated for functional status. The DON revealed she believed environmental services periodically checked the system, but was unaware of when or how often the system was checked.</p> <p>Interviews with the Administrator, on 06/23/10 at 2:45 PM and on 06/24/10 at 2:20 PM, revealed the emergency call lights in the resident bathrooms and shower rooms should be checked periodically for functioning. She stated environmental services checked the system, but was unsure of when or how often the checks were conducted.</p>	F 463	Performance monitoring: the safety committee will conduct monthly reviews of compliance rounds and ensure any discrepancies were corrected.	

Addendum to Plan of Correction
Haws Memorial Nursing & Rehabilitation Center
Completion date of Survey: 06/25/10

Addendum to F281 To monitor performance the designee is defined as: one of two RN Administrative Nurses.

Addendum to F323 To monitor performance the designee is defined as: one of two RN Administrative nurses.

Janet H. Conner
Administrator

07-19-10



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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2010
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 A Life Safety Code survey was initiated and conducted on 06/23/10 to determine the acility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 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.