

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

PRINTED: 06/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2010
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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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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
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F 000	<p>INITIAL COMMENTS</p> <p>An annual recertification survey was conducted 05/19/10 through 05/21/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D".</p> <p>F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible. The facility failed to ensure five residents (#1, #3, #7, #8 and #9), in the selected sample of 10, were assessed to determine each resident's individual safety related to the use of speciality air mattresses. Additionally, the facility failed to assess one resident (#1), to determine safety related to the use of a bed bolster pad, in conjunction with the alternating pressure mattress. Findings include:</p> <p>1. Record review revealed Resident #1 was admitted to the facility, on 08/06/08, with diagnoses which included multiple pressure ulcers, Osteoporosis, Osteopenia, and Alzheimer's Disease.</p>	F 000	<p>F323</p> <p>1. How will corrective action be accomplished for:</p> <p>a. Resident #1 – On 5/20/10, Resident #1 reassessed using new tools for appropriateness of use of air mattress and positioning device in addition to risks versus benefits of use. See Attachments 1 and 2.</p> <p>b. Resident #9 – On 5/20/10, Resident #9 was reassessed using new tool for appropriateness of use of air mattress in addition to risks versus benefits of use. See Attachment 3.</p> <p>c. Resident #8 – On 5/20/10, Resident #8 was reassessed using new tool for appropriateness of use of air mattress in addition to risks versus benefits of use. See Attachment 4.</p> <p>d. Resident #3 – On 5/20/10, Resident #3 was reassessed using new tool for appropriateness of use of air mattress in addition to risks versus benefits of use. See Attachment 5.</p> <p>e. Resident #7 – On 5/20/10, Resident #7 was reassessed using new tool for appropriateness of use of air mattress in addition to risks versus benefits of use. See Attachment 6.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Beechy Jurgens, NNA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>06/10/10</i>
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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 323	<p>Continued From page 1</p> <p>A review of a Fall Risk Assessment, dated 02/25/10, revealed the facility assessed Resident #1 at high risk for falls with a score of 28 points; a score of 12 or higher indicated a high risk for falls.</p> <p>A review of the resident's (undated), care plan for the problem, "Impaired Skin Integrity" revealed interventions included the use of an "air loss" mattress on the resident's bed. Review of the care plan for the problem, "Falls/Safety", dated 07/13/09, revealed interventions included the use of a bed bolster to be placed to the right side of the bed, "to aid with positioning".</p> <p>A review of physician orders, dated 05/01-31/10, revealed an order for the air mattress and revealed the start date, of 08/06/08. Additionally, the physician orders included the use of a bolster to be applied to the right side of the bed for positioning, with a start date of 02/26/10.</p> <p>A review of nurses notes, dated 04/19/10 at 9:00 PM, revealed Resident #1 rolled over the bed bolster and fell on the floor. The resident sustained skin tears to the left knee, upper right arm, and between first and second fingers of the left hand. A bruise was noted to the resident's right cheek and a blood blister was noted on the resident's right eyelid. The note revealed Resident #1 complained of pain to the head and neck, the physician was notified and an order was received to obtain a x-ray of the resident's cervical (neck) spine and both hands.</p> <p>A review of the x-ray report, dated 04/19/10 at 11:04 PM, revealed Resident #1 sustained an acute (recent) fracture to the second vertebra in the cervical spine (neck). The x-ray report also revealed the resident had Kyphosis (exaggerated</p>	F 323	<p>F323 continued</p> <p>2. How will facility identify other residents:</p> <p>a. On 5/20/10, trial worksheets were developed to complete a 100% audit for all residents using a low air loss mattress and/or a positioning device in the Long Term Care Facility. A summary of this audit was completed. See Attachment 7.</p> <p>3. Measures put in place to ensure deficient practice will not recur:</p> <p>a. Policy on "Positioning/Mobility and Pressure Reduction Devices" was written that includes an evaluation of the need for mobility and positioning devices as well as proper assessment of use of pressure reduction devices to include the potential risk, benefit, evaluation of benefit versus risk and rationale for use of any such device. See Attachment 8 – 2 pages.</p> <p>b. The assessment on Bedrail/Fall Assessment was updated to include assessment of positioning/mobility devices and pressure reduction devices. See Attachment 9 – 3 pages.</p> <p>c. Mandatory in-services have been scheduled for all licensed and CNA staff to review completion of new areas of assessment identified in policy. See Attachment 10 – 2 pages, and Attachment 11.</p>		

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F 323	<p>Continued From page 2</p> <p>curvature of the upper spine) and chronic (old or longstanding) compression fractures to the second and third vertebra of the thoracic (upper back) spine.</p> <p>A review of the "falls monitor", dated completed, on 04/22/10, by the facility's Administrator, revealed the reason the resident fell was due to "restlessness/confusion". The Administrator documented in the section entitled "problems identified from this review", the cause for the fall was not determined, the resident resident seldom moved in bed and the resident would be monitored closely.</p> <p>An interview conducted, on 05/20/10 at 1:20 PM, with Licensed Practical Nurse (LPN) #2 revealed the nurse found Resident #1 on the floor, on 04/19/10, and the resident had been observed by the nurse to have episodes of restlessness while in bed. LPN #2 described the resident as having episodes of "squirming and turning", while in the bed. She stated she could not determine how Resident #1 was able to roll over the bed bolster and fall to the floor. LPN #2 stated she did not assess the resident for the safe use of the air mattress or the bed bolster, prior to continuing the use of the devices. However, she asked the Certified Nursing Assistants (CNA) to check the bed and bed bolster to ensure they were in place, prior to assisting Resident #1 back into the bed.</p> <p>An interview with LPN #1, on 5/20/10 at 2:40 PM, revealed she had obtained the order for the bed bolster, on 02/26/10. Resident #1 had a Stage IV pressure area to the upper right back and frequently rolled to the right side. The bed bolster was utilized to prevent the resident from rolling onto the pressure area after use of pillows for</p>	F 323	<p>F323 continued</p> <p>d. Updated competencies will be completed on all staff. See Attachments 12.</p> <p>4. Monitor performance to ensure that solutions are sustained: a. Quality Assurance worksheet established for on-going monitoring. See Attachment 13. b. Monitoring will be completed and reported monthly to all Long Term Care staff, and quarterly to Quality Assurance Committee.</p> <p>5. Date of Completion of all corrective action to correct this deficiency – 6/24/10.</p>	6/24/10	

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F 323	<p>Continued From page 3</p> <p>positioning was unsuccessful. LPN #1 stated she discussed the resident's care with other nursing staff, but the resident was not assessed for the use of the device to ensure it was safe. LPN #1 stated she was unaware of any procedure developed by the facility to be completed prior to implementing a positioning device, such as the bed bolster or the air mattress. When a resident was admitted to the long term care (LTC) facility from the hospital portion of the building, if they were received on an air mattress and had a physicians order for the mattress, no assessment was conducted.</p> <p>An interview with the Administrator and Director of Nursing (DON), on 05/20/10 at 3:05 PM, revealed the cause of the resident's fall was not determined. The Administrator stated the facility did not have an established policy related to assistive device (air mattress or bed bolster) assessments to ensure safety for the resident, prior to implementation.</p> <p>An interview with Registered Nurse (RN) #2, staff development coordinator, on 05/21/10 at 10:35 AM, revealed CNAs were responsible for checking placement of bed bolsters every shift, but she was not sure whether the CNAs had been trained and were competent to ensure proper placement of a device. She stated she would expect licensed staff to ensure the placement of the bed bolster initially, but did not know who was designated responsibility. RN #2 stated inservices on the placement and use of bed bolsters had been provided, on 05/18/10, in response to a request made by LPN #2.</p> <p>An interview with the Administrator, on 05/21/10 at 12:30 PM, revealed she could not locate</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>evidence of training provided by the facility for the use of bed bolsters, prior to 05/18/10. Prior to 05/18/10, guidelines for applying the bed bolsters was posted on the bathroom door of Resident #1's room and each CNA was supposed to read the guidelines prior to applying the bolster.</p> <p>An interview with LPN #1, on 05/21/10 at 1:10 PM, revealed she requested the inservice because she found the bed bolster applied loosely previously.</p> <p>An interview with CNA #3, on 05/21/10 at 1:15 PM, revealed she found the bolster applied loosely, previously.</p> <p>An interview with CNA #4, on 05/21/10 at 1:30 PM, revealed she received training related to the use of air mattresses and licensed staff talked to her about the bed bolster, but the CNA had not received formal inservices or training related to the application of the bed bolster.</p> <p>An interview with CNA #5, on 05/21/10 at 1:35 PM, revealed she had been employed approximately two months, had not received any training on either the air mattress or the bolster and would not know how to apply a bed bolster.</p> <p>An interview with CNA #7, on 05/21/10 at 1:55 PM, revealed she had been employed approximately six months and had no formal training or inservices since hire, related to bed bolsters or air mattresses, prior to 05/18/10.</p> <p>An interview with Resident #1's family member, on 05/20/10 at 2:30 PM, revealed the facility had not informed the relative of a determination of a cause of the resident's fall. The family member</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>stated Resident #1 had been observed very restless in bed at times, but had not been observed attempt to get out of bed.</p> <p>Observations of Resident #1, on 05/19/10 at 10:20 AM and 3:40 PM, revealed Resident #1 was in bed and the bed was equipped with an air mattress and a bed bolster was applied to the right side of the bed. The bed was observed in a low position, fall mats were located on both sides of the bed and a bed sensor alarm was in place and activated. The resident was not observed restless during the observations.</p> <p>2. A record review revealed Resident # 9 was admitted to the facility with diagnoses to include End Stage Parkinson's Disease, Diabetes Mellitus, Parotid Gland Infection, Weight Loss and Pressure Ulcer.</p> <p>Observations of Resident #9, on 05/20/10 at 4:50 PM and on 05/21/10 at 10:00 AM, revealed the resident was lying on an air mattress, with side rails on both sides of the bed, in the down position.</p> <p>A review of the physician's orders, dated 05/17/10, revealed the order for the air loss mattress.</p> <p>A review of the care plan, dated 05/17/10, revealed the resident was on an air loss mattress.</p> <p>A review of the medical record revealed there was no assessment identifying risks or benefits for the safe use of the air loss mattress.</p> <p>3. A record review revealed Resident #8 was admitted to the facility with diagnoses to include</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>Decubitus Ulcer, Diabetes Mellitus, Hypertension, Coronary Artery Disease, Congestive Heart Failure, Pacemaker and History of Humerus Fracture.</p> <p>Observations on 05/20/10 at 1:15 PM and 05/21/10 at 5:00 PM, revealed Resident #8 was lying on an air mattress with the siderails in the up position.</p> <p>A review of the physician's order dated 02/10/2009, revealed an order for an air mattress.</p> <p>A record review revealed there was an assessment completed on 05/21/10 to identify the risks and benefits for the safe use of the air mattress.</p> <p>4. Resident #3 was admitted to the facility with diagnoses to include Multiple Decubiti, Renal Insufficiency and Diabetes Mellitus.</p> <p>An observation on 05/19/10 at approximately 10:25 AM, revealed Resident #3 was lying on an air mattress with the side rails of the bed in the down position.</p> <p>A review of a physician's order dated 05/10, revealed an air loss mattress was to be utilized.</p> <p>A review of Resident #3's care plan for Impaired Skin Integrity dated 05/03/10, revealed an intervention for "air loss mattress" as a pressure relieving support surface.</p> <p>A review of the medical record revealed there was no assessment completed for the safe use of an air mattress.</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>5. Resident #7 was admitted to the facility with diagnoses to include Multiple Myolemma, Hip Fracture and Chronic Pain.</p> <p>An observation on 05/20/10 at approximately 1:25 PM, revealed Resident #7 was lying on an air mattress with 1/2 side rails bilaterally in the up position.</p> <p>A review of the admission physician's orders dated 05/10/10, revealed an order for an air mattress.</p> <p>A review of the medical record revealed no assessment had been completed for the safe use of an air mattress.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator on 05/20 10 at approximately 4:45 PM, revealed no assessments were completed for the safe use of an air mattress for Residents #3 and #7. Additionally, the MDS Coordinator revealed if residents were admitted from the acute care hospital with an order for an air mattress, then no assessments were completed.</p>	F 323			

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K 000	INITIAL COMMENTS	K 000		
K 062 SS=E	<p>A Life Safety Code survey was initiated and conducted on 05/20/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an E.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05/20/10, it was determined the facility failed to ensure sprinkler heads were free of paint as required by NFPA 25 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility, conducted 05/20/10 at 11:00 AM, revealed seven sprinkler heads in the kitchen had a build-up of lint and dust.</p> <p>An interview with the Maintenance Director, on 05/20/10 at 11:05 AM, revealed he was unaware of the build-up of lint and dust on the sprinkler heads.</p> <p>Reference to: NFPA 25 1999 Edition 2-2 Inspection.</p>	K 062	<p>K062</p> <p>1. How will corrective action be accomplished for identified automatic sprinkler systems: a. All 7 sprinkler heads identified during the tour of the facility were cleaned by 8:30 p.m. on 5/20/10 by Environmental Staff as evidenced by "Preventative Maintenance" report. See Attachment 14.</p> <p>2. How will facility identify other areas of concern: a. On 5/20/10, all sprinkler heads were reviewed and evaluated for state of cleanliness in the entire Dietary Department.</p> <p>3. Measures put into place to ensure deficient practice will not recur: a. Established Preventative Maintenance form to be completed monthly. See Attachment 15.</p> <p>4. Monitor performance to ensure that solutions are sustained:</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Becky Quigley, NNA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>06/10/10</i>
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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 062	Continued From page 1 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	K062 continued a. Director of Plant Operations will review all PMs on a monthly basis. 5. Date of Completion of all corrective actions to correct this deficiency: 5/21/10.	5/21/10	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05/20/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Observations during the Life Safety Code tour conducted on 05/20/10 at 10:15 AM, revealed the doors to the following rooms #103, #105, #106, #108, #109, #111, #112 and #115 were decorated with wreaths. An interview conducted with the Maintenance Director on 05/20/10 at 10:20 AM, revealed the wreaths had been put on the doors by family members and the facility did not have any documentation that would indicate the flame rating of the wreaths on the doors.	K 073	K073 1. How will corrective action be accomplished for identified concerns related to combustible decorations: a. All wreaths on doors in Rooms 103, 105, 106, 108, 109, 111, 112, and 115 were sprayed with appropriate flame-retardant as required by NPFA. See Attachment 16. 2, How will facility identify all areas of concern related to this deficiency: a. A 100% audit was completed of all rooms including each resident room, both sunrooms, and hallways to identify any potentially combustible decorations in place requiring flame-retardant spray using the tool developed. See Attachment 17. b. All identified items were treated with flame-retardant spray. 3. Measures put into place to ensure deficient practice will not recur: a. Statement in Resident Information Packet. See Attachment 18.		



K073 continued

b. Provide announcement to Resident Council Meeting.

c. Provide updated information to all staff related to identification of "Resident Flammable Materials List". See Attachment 19.

d. Sign placed in resident rooms to alert current residents/families about any flammable materials brought in. See Attachment 20.

e. New policy written to define flammable materials and treatment of such. See Attachment 21.

4. Monitor performance to ensure that solutions are sustained:

a. Environmental floor rounds will be conducted monthly and personal items will be examined for safety and reported as necessary.

5. Date of Completion of all corrective actions to correct this deficiency: 6/30/10
6/30/10.