

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/15/2015
NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143		
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F 000	INITIAL COMMENTS A Recerification Survey was initiated on 10/13/15 and concluded on 10/15/15 with deficiencies cited at the highest scope and severity of an "F". An Abbreviated Survey was initiated on 10/14/15 and concluded on 10/15/15 to investigate KY23933. The Division of Health Care unsubstantiated the allegation with unrelated deficiencies cited.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	It is the practice of this facility to provide residents' with a copy of the Medicare Notice of Non-coverage upon discharge.	11/28/15	

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

TITLE

(X6) DATE

J. Power

x Administrator 11/19/15

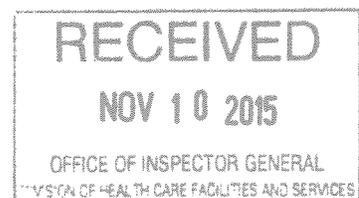
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

RECEIVED

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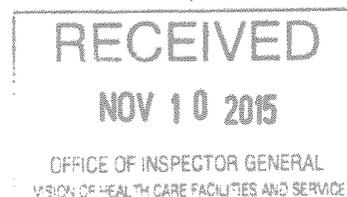
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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	1. Medicare Notices of Non-coverage for Resident # 14 and un-sampled resident E were certified mailed on 11/9/15. Un-sampled residents C & D were discharged to a higher level of care and fit into exception criteria. Un-sampled resident B's discharge notice was provided to resident B and signed on 9/10/15. 2. The facility Administrator completed an audit on 10/19/15 which encompassed residents with Medicare coverage. The audit focused on Medicare residents from 4/1/15 through 10/19/15 who were discharged to a lower level of care and had remaining Medicare days. The audit revealed no additional concerns identified. 3. The Administrator on 11/4/15 conducted an educational review for the Social Services Director, the Business Office Manager and the MDS nurse of F 156 as it relates to providing residents with a copy of the Medicare Notice of Non-coverage upon discharge. The Business Office Manager will be responsible for completing and	



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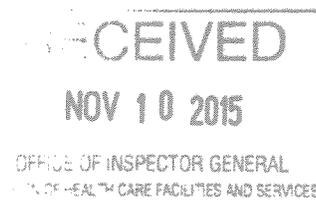
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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide Medicare Notice of Non-coverage to one of fourteen (14) sampled residents (Resident #14) and four (4) of eleven (11) unsampled residents (Unsampled Residents B, C, D, and E) discharged while still on Medicare. The findings include: The facility did not provide a policy related to providing Medicare Notice of Non-coverage. 1. Review of the clinical record for Resident #14, revealed the facility discharged Resident #14 on 09/24/15 and did not provide a Medicare Notice of Non-coverage. 2. Review of the clinical record for Unsampled	F 156	issuing denial letters for Medicare residents who are discharging home in the absence of the Social Service Director. 4. The Administrator will conduct a weekly audit for 4 weeks and monthly for 5 months, of Medicare residents with planned discharges for the upcoming week and validate that a denial letter to the resident and or Guardian is being issued. The Administrator will then review Medicare residents discharged the previous day (or over the weekend) to assure that a denial letter was completed and issued to the resident and or Guardian per regulation. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for its review and recommendation monthly. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.	



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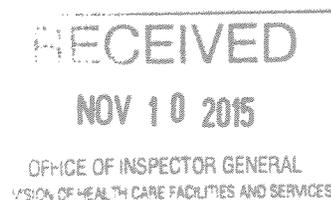
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F 156	<p>Continued From page 3</p> <p>Residents B, revealed the facility discharged the resident on 09/10/15 and did not provide a Medicare Notice of Non-coverage to the resident.</p> <p>3. Review of the clinical record for Unsampled Resident C, revealed the facility discharged the resident on 08/19/15 to the Hospital and did not provide a Medicare Notice of Non-coverage to the resident.</p> <p>4. Review of the clinical record for Unsampled Resident D, revealed the facility discharged the resident on 09/16/15 to the Hospital and did not provide a Medicare Notice of Non-coverage to the resident.</p> <p>5. Review of the clinical record for Unsampled Resident E, revealed the facility discharged the resident on 10/02/15 to an Assistive Living Facility and did not provide a Medicare Notice of Non-coverage to the resident.</p> <p>Interview with the Business Office Manager, on 10/15/15 at 3:30 PM, revealed the Social Services Director was responsible to provide the Medicare Notice of Non-coverage, but she left on 09/18/15 and the Administrator took on the role of providing the notices. The Business Office Manager stated residents should be afforded the right to know how many days were left with medicare. The Business Office Manager stated she was never directed to provide letters of Medicare non-coverage to residents.</p> <p>Interview with the Administrator, on 10/15/15 at 3:42 PM, revealed when the Social Services Director left she did not assign anyone to do the task of providing letters of Medicare non-coverage to the residents, nor did she</p>	F 156		



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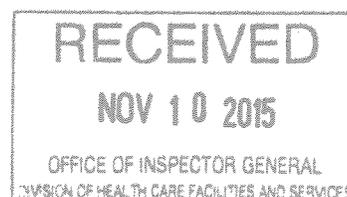
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F 156	Continued From page 4 complete the task. The Administrator stated the residents had the right to know how many days they had left for their Medicare coverage.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to resolve two (2) grievances for one (1) of fourteen (14) sampled residents and eleven (11) unsampled residents. (Unsampled Resident F). The facility prohibited Unsampled Resident F to go out doors and smoke. The facility further failed to address Unsampled Resident F's concerns voiced regarding repeated foods served and served cold. The findings include: Review of the facility's policy regarding Resident and Family Grievances, not dated, revealed grievances could be voiced without discrimination or reprisal. Grievances would be resolved promptly. Grievances would be documented on the Grievances/Concern Form. Review of the clinical record for Unsampled Resident F, revealed the facility completed a quarterly Minimum Data Set assessment with a Brief Interview for Mental Status on the resident	F 166	It is the practice of this facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. 1. As indicated in the 2567, Resident F was aware of the facility no smoking policy. Prior to the concern voiced to the surveyor, facility management was not aware of any concern regarding Resident # F and smoking. Resident #F does / did not possess cigarettes and therefore would not have been able to smoke without them. Resident F has acknowledged the facility Smoke Free Tobacco Free Campus Acknowledgement and has been offered transfer to a smoking facility which she has declined. The dietary manager has followed up with Resident F's concerns regarding cold eggs and toast with hard edges and a new concern form has been completed.	11/28/15



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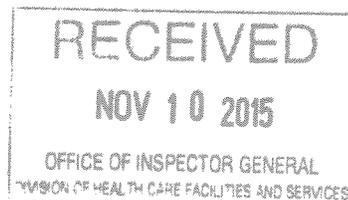
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F 166	<p>Continued From page 5</p> <p>on 09/28/15. The resident scored a fifteen (15) out of fifteen (15) and was interviewable.</p> <p>Interview with Unsamped Resident F, on 10/13/15 at 2:15 PM, during the Group Interview, revealed the resident was alert and oriented to person, time and place with clear speech and the ability to verbally state concerns with the facility. The resident was aware of the no smoking in the facility policy. The resident stated he/she observed employees outside in the back of the parking lot smoking and wanted to go outside and smoke. The resident stated he/she was stopped at the front door, which was alarmed and required a code to exit, and told he/she could not go outside and smoke. The resident stated that each time he/she attempted to go outside, staff refused to allow the resident to exit the building. The resident stated a relative came to the facility twice a week and drove him/her around the block so the resident could smoke. The resident stated repeated complaints were met with a no answer.</p> <p>Review of the Admissions Resource Guide, page 6, signed by Unsamped Resident F, on 03/19/15, revealed smoking was not permitted in residents' rooms, corridors, or common areas. Smoking was permitted in designated public areas unless the entire building was smoke free.</p> <p>Observation of the signage on the front of the facility, on 10/13/14 at 2:41 PM, revealed the facility was a non-smoking facility. In addition, a metal sign was mounted close to the front door advising that there was no smoking in this outside area where outdoor chairs were available for residents. There was no posting observed notifying residents or the public that the facility was a no smoking campus. There was an</p>	F 166	<p>2. The facility grievance procedure will be followed which includes a timeframe for getting back to the resident and/or responsible party with a resolution to the concern. The Administrator will review new grievances as well as resolution to prior grievances daily, 5 days per week, during the facility stand up meeting. A concern box has been placed at the administrators' office door to allow residents' to file a report of abuse, a complaint or a suggestion anonymously. A Resident Acknowledgement of Non-Smoking Policy has been added to the Admissions packet. Current residents or legal representatives are also signing the Acknowledgment. The Dietary Manager has formed a resident food committee to be held monthly. The Dietary Manager will maintain minutes of the food committee meeting and follow up with resident concerns as indicated. The smoking policy and grievance process will be reviewed with residents at the Resident Council Meeting on 11/17/15.</p>		



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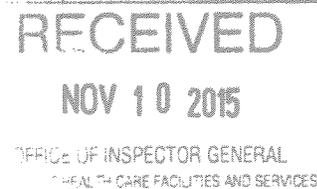
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F 166	<p>Continued From page 6</p> <p>employee out by the back parking lot smoking. Continued observations of the back parking lot, on 10/13/15 at 3:44 PM, revealed two employees were smoking.</p> <p>Interview with Certified Nurse Aide (CNA) #7, on 10/14/15 at 9:07 AM, revealed Unsampled Resident F was not allowed to go outside alone. She stated the resident might smoke and residents were not allowed to smoke inside or outside. She stated she knew employees smoked outside. She stated she received training on resident rights, however, she had to follow the rules. She stated she knew the resident's sister visited several times a week to take the resident riding so the resident could smoke.</p> <p>Interview with the Administrator, on 10/15/15 at 3:45 PM, revealed grievances were addressed timely and there was no set time frame for a grievance to be answered. She stated she answered Unsampled Resident F's grievances with a no. She stated smoking was not allowed outside except for employees. She stated she did not want the resident smoking outside so the resident was not allowed to go outside unless a staff member went with the resident to ensure the resident did not smoke. She stated the resident's sister visited twice a week and drove the resident around so the resident could smoke. She stated she had no written policy regarding a smoke-free campus. She stated she knew the resident wanted to go outside and smoke; however, the resident would not be allowed to do that.</p> <p>2. interview with Unsampled Resident F, on 10/15/15 at 3:13 PM, revealed the meals served by the dietary staff were not appetizing because the eggs were cold every morning, and he/she did</p>	F 166	<p>3. The Administrator on 11/3/15 conducted an educational review for the Dietary Manager on the food committee meeting, documentation thereof and follow up to resident food concerns. The Administrator on 11/4/15 and the Director of Nursing on 10/27/15 conducted an educational review for facility staff on F 166 as it relates to the Grievance procedure and timely follow up.</p> <p>4. The facility Administrator will conduct a monthly audit for 6 months of the resident food committee meeting minutes to verify prompt follow up with resident concerns. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee monthly for its review and recommendations. The facility NHA will conduct an audit of resident grievances daily, 5 days per week for 3 months during AM stand up meeting to validate timely follow up. The NHA will go to resident council monthly for three months to follow</p>	



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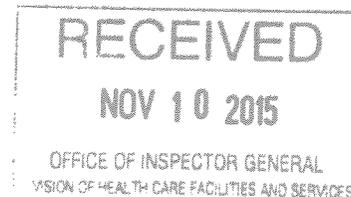
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F 166	Continued From page 7 not like to eat cold scrambled eggs. He/She stated they were tired of the same things every morning at breakfast. Unsampld Resident F stated the toast was hard and had voiced concerns to a staff person, (whom he/she did not name), and the staff person filled out the Resident Concern Form on his/her behalf because the facility did not have any process in place for the resident to file an anonymous grievance. Unsampld Resident F also stated after the grievance was filed by the staff person the Dietary Manager came to visit a couple of times, but she had not been back in months and the food problems still existed. Review of a Resident Concern Form, dated 07/23/15, revealed a grievance was filed with the facility by Unsampld Resident F that stated he/she wanted something different for breakfast because it was the same meal every morning and was tired of it. The Resident Concern Form was investigated and the findings concluded that the food at breakfast was cold. Further, Unsampld Resident F wanted toast that was not hard around the edges, and a suggestion was made to add pancakes and/or waffles to the breakfast menu. The Resident Concern Form's disposition, dated 07/28/15, five (5) days later, also revealed the Dietary Manager visited Unsampld Resident F and instructed the resident if the breakfast food was cold when brought to him/her, that he/she should have asked one of the CNAs to reheat it to the preferred temperature and that pancakes and/or waffles had been added to the breakfast menu for once a week. The Dietary Manager also stated on the Resident Concern Form that she would check with the resident every other morning to ensure the complaint was resolved.	F 166	up on the grievances with residents. Any discrepancy in the audit will be corrected at that time. Results of the audit will be submitted monthly to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for its review and recommendations. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.		



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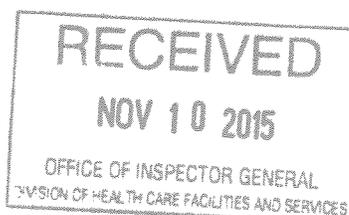
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F 166	Continued From page 8 Interview with the Dietary Manager, on 10/15/15, at 3:20 PM, revealed the dietary staff went into Unsampld Resident F's room every week to check on his/her complaint. The Dietary Manager stated that within the past two weeks they had not checked on Unsampld Resident F. The Dietary Manager also stated that she honestly thought there was nothing they could do to satisfy Unsampld Resident F's needs.	F 166		
F 253 SS=E	Interview with the Administrator, on 10/15/15, at 3:31 PM, revealed the facility had not had a process or procedure in place that allowed a resident to file a report of abuse, a complaint, nor a suggestion anonymously. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have a system in place to ensure the resident's environment was comfortable and repairs were completed for twenty-two (22) of thirty-two (32) rooms, (Rooms 1, 2, 4, 5, 6, 7, 10, 12, 16, 17, 18, 19, 20, 21, 22, 23, 24, 28, 30, and 31). Door frames had chipped paint, walls had gypsum exposed, and toilet paper holders and towel racks were broken. The facility failed to ensure bathroom (BR) tiles were in good condition for four (4) of eighteen (18) shared bathroom floors, (BR 26 and 28, 25 and 27, 21 and 23, 10 and 12).	F 253	It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. The door frames of rooms 1, 2, 4, 5, 6, 7, 10, 12, 16, 17, 18, 19, 20, 21, 22, 23, 24, 28, 30 and 31 will be repainted by 11/6/15. Door Frames of East Shower Room, Medical Records, Laundry Room, and Dirty Linen room door will be painted by 11/6/15. Gouged hallway walls on East and West unit will be touched up by 11/6/15. Missing toilet paper roll on shared bathroom for resident rooms 30 and 32, 6 and 8 were replaced on 10/16/15.	11/28/15



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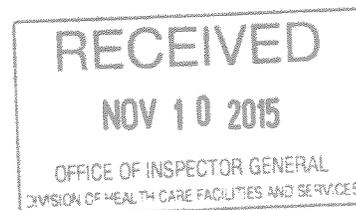
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F 253	Continued From page 9 The findings include: The facility did not provide any policies regarding Maintenance or Housekeeping. 1. Observation of the East Unit, on 10/13/15 at 8:40 AM, revealed chipped paint around door frames of multiple resident rooms (Rooms 17, 18, 19, 20, 21, 22, 23, 24, 28, 30, and 31). In addition, the East Shower Room and the Medical Records door frame had chipped paint. The hallway walls on the East Unit were gouged in multiple places with exposed gypsum and missing paint. 2. Observation, of the one shared bathroom for Resident Rooms 30 and 32 on the East Unit, on 10/13/15 at 8:47 AM, revealed a missing toilet paper holder with a roll of toilet paper sitting on the back of the toilet. 3. Observation, on 10/13/15 at 8:50 AM, revealed brwn/tan stained tiles around the bases of toilets in shared resident bathrooms (BR 26 and 28, 25 and 27, and 21 and 23). In addition, the bathroom servicing residents in Rooms 25, 27, and Rooms 21 and 23 had broken towel racks. 4. Observation of the West Unit, on 10/13/15 at 10:00 AM, revealed chipped paint around the door frames of resident rooms (Rooms 1, 2, 4, 5, 6, 7, 10, 12, and 16). The door and door frame of the Laundry Room had peeling paint, and the door frame to the Dirty Linen room had chipped paint. The hallway walls on the West Unit were gouged in multiple places, with exposed gypsum, and missing paint; primarily on the lower portion of the walls.	F 253	Brown/tan stained tiles around bases of toilets in shared bathrooms 26 and 28, 25 and 27, 21 and 23, and 10 and 12 have been cleaned and/or will be replaced by 11/23/15. Shared bathroom between room 6 and 8 broken tile on the wall to the left of toilet and radiator cover was fixed by 10/30/15. Broken towel rack in shared bathroom 7 and 9 was removed and broken radiator cover in same bathroom was fixed by 10/30/15. Broken towel racks is shared bathroom 25 and 27, and 21 and 23 were removed by 10/30/15. Dining room door frames were painted by 11/6/15 and gouged walls with missing paint will be touched up by 11/13/15. 2. The week of 11/2/15 the Housekeeping Supervisor and Maintenance Director did a walking tour of building to identify rooms having the same deficient practice. 3. The facility will identify maintenance and housekeeping issues through department head room rounds, housekeeping and maintenance supervisor observations		



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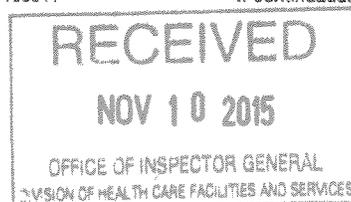
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F 253	Continued From page 10 5. Observation of the one shared bathroom between Room 6 and 8, on 10/13/15 at 10:11 AM, revealed a missing toilet paper holder with toilet paper sitting on the back of the toilet. In addition, there was a broken tile on the wall to the left of the toilet, and the radiator cover was broken. 6. Observation, on 10/13/15 at 10:20 AM, revealed brown/tan stained tiles around the base of the toilet in the bathroom shared by Room 10 and 12. In addition, there was a broken towel rack and broken radiator cover in the shared bathroom for residents in Rooms 7 and 9. 7. Observation of the Dining Room, on 10/14/15 at 8:00 AM, revealed chipped paint around the two door frames leading into the Dining Room. The walls of the Dining Room were gouged, and had missing paint where the tables sat against the walls. In addition, the lower portion of the wall across from the dining room had a long scrape with exposed gypsum, and missing paint. Interview with the Housekeeping Supervisor, on 10/15/15 at 8:20 AM, revealed she had two housekeepers on staff daily. Housekeeping duties included: emptying trash; sweeping and mopping floors; and dusting daily. She stated she did housekeeping rounds four (4)-five (5) times per day to ensure tasks were completed. In addition, she stated she knew of the discolored floors in resident bathrooms, and stated the floors were old. Interview with the Maintenance Supervisor, on 10/15/15 at 8:30 AM, revealed he was the only person on the maintenance staff. He stated he did not complete daily rounds in resident rooms	F 253	and observations of facility staff. The facility rounds tool was updated by the administrator to be used on walking rounds by department heads. Facility staff will fill out maintenance and/or housekeeping work orders as indicated. The Administrator on 11/4/15 has provided the facility department heads an educational review <ul style="list-style-type: none"> regarding the regulation F 253 as it pertains to housekeeping and maintenance services as well as Completion of room rounds and the rounds forms. 4. The facility Administrator will complete an audit of facility rooms to validate follow up with work orders by maintenance and housekeeping service. This audit will be conducted on 4 chosen rooms and / or work orders to verify department head room rounds are being completed correctly with follow up as indicated by maintenance and/or housekeeping. This audit will be conducted weekly for 4 weeks then monthly for 5	



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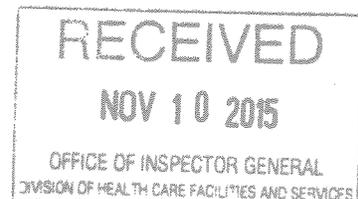
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F 253	Continued From page 11 or bathrooms, and relied on other staff to identify maintenance concerns. The Maintenance Supervisor stated if something was in disrepair, staff would be expected to fill out a work order request and place it in the work order file located on the West Unit. He stated he was unaware of the broken radiator cover, broken tile, and missing toilet paper holder in the shared bathroom between Resident Rooms 6 and 8. He was also unaware of the broken towel rack and radiator cover in the bathroom shared by residents in rooms 7 and 9. The Maintenance Supervisor did not have any current work orders for either bathroom, and stated he would expect to see a work request for those issues. In addition, he stated he prioritized tasks and did not have time to repair the gouged walls throughout the building. Interview with the Administrator during the Environmental Tour, on 10/15/15 at 8:50 AM, revealed Department Heads were responsible for completing daily environmental rounds of assigned resident rooms and bathrooms. She met with Department Heads daily during the morning meeting and was unaware of any environmental concerns. The Administrator stated she would expect concerns to be reported to the Maintenance Supervisor. In addition, she stated the floors were old and the East Unit needed to be repainted. The Administrator stated she was hoping to get new floors and paint for the East Unit, but nothing had been approved at this time. She stated she was responsible for making rounds in the facility.	F 253	months. Results of these audits will be submitted to the facility QUALITY ASSURANCE PERFORMANCE IMPROVEMENT Committee monthly for its review and recommendation. Any discrepancy in the audit will be addressed at that time. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			



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F 282	<p>Continued From page 12</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 staff followed the care plan of one (1) of fourteen (14) sampled residents and eleven (11) unsampled Residents, (Unsampled Resident A). The staff failed to complete bathing two (2) to three (3) times a week and shave the resident daily as care planned and requested by the family.</p> <p>The findings include:</p> <p>The facility did not provide a policy for revision of the care plans</p> <p>Review of the clinical record for Unsampled Resident A, revealed the facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 09/09/15 which revealed the resident was given a Brief Interview for Mental Status and scored a fifteen (15) out of fifteen (15) and was interviewable. In addition, the resident had no moods and one (1) expression of verbal behavior during the assessment period.</p> <p>Review of the comprehensive care plan, dated 09/01/15, for Unsampled Resident A, revealed the resident received a shower two (2) to three (3) times weekly and more often as needed, and explain care to the resident prior to beginning. Staff was to ensure necessary equipment and</p>	F 282	<p>It is the practice of this facility that services provided are by qualified individuals in accordance with each resident's written plan of care</p> <p>1. Resident A has been a resident since 2004. He has agreed to a shower and a shave following survey exit. He continues to refuse showers 3 times per week, and refuse offers by staff for daily shaves at times. He states he "will not be shaved every day" and he "will not be showered three times a week". Each time he refuses, the family is notified. Facility has requested the family to come to facility and assist with coaxing resident to shower and/or shave. The family has not been back to facility to assist with coaxing. On 11/6/15 Director of Nursing and Administrator asked resident why he has been refusing showers and shaves and he said "it doesn't matter what his daughter wants, it matters what he wants." We asked resident how often he wanted to be showered and he said twice a week. We asked resident how often he wants to be shaved and he said only on shower days. Director of Nursing educated resident on importance of daily care and hygiene. The care plan has been</p>	11/28/15



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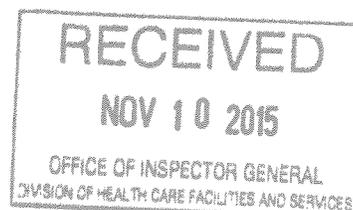
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F 282	<p>Continued From page 13</p> <p>adequate time for the task to be accomplished. A care plan entry on 10/14/15 revealed staff was to shave the resident daily and give the resident three (3) showers per week per family request. A care plan entry on 10/15/15 stated the resident did not want to be shaved daily or showered three (3) times a week.</p> <p>Observation of Unsampled Resident A, on 10/13/15 at 4:10 PM, revealed the resident was in a wheelchair in the common area. The resident had facial hair and was dressed in clothes with a flannel jacket/shirt over the top. The resident had a heavy stubble of facial hair and had a faint odor of urine.</p> <p>Observation of Unsampled Resident A, on 10/14/15 at 11:40 AM, revealed the resident was sitting in the dining room, in a wheelchair, having lunch. The resident had a urine odor and a heavy growth of facial hair.</p> <p>Observation of Unsampled Resident A, on 10/14/15 at 5:40 PM, revealed the resident was sitting in the common area with other residents watching television. The resident had a heavy growth of facial hair and smelled strongly of urine.</p> <p>Interview with Unsampled Resident A, on 10/14/15 at 11:40 AM, revealed the resident shaved on a daily basis prior to coming to the nursing facility. The resident stated assistance of staff was needed related to severe weakness in the left arm and hand from a stroke. The resident stated staff did not ask when the resident wanted a bath or a shave and the resident had to be ready whenever the staff was. The resident stated the facility tried to make him/her wear an adult pull-up. The resident stated he/she had</p>	F 282	<p>reviewed and updated to reflect resident behaviors and self-determination.</p> <p>2. The Assistant Director of Nursing on 10/15/15 and 11/6/15 conducted an audit of resident scheduled shower days and times, and update the shower schedule according to resident preferences. Care plans will be updated by the according to resident shower preferences for days and shifts. The C N A care plan (accu nurse) will be updated by the Assistant Director of Nursing to include cueing the C N A to record completion of grooming and showers</p> <p>3. The Director of Nursing on 10/27/15 completed an educational review for the nursing staff regarding:</p> <ul style="list-style-type: none"> the regulation F 282 as it relates to provision of care (to include showers and shaving) and following the care plan C N A notification to the charge nurse if the resident refuses care / showers and shaving

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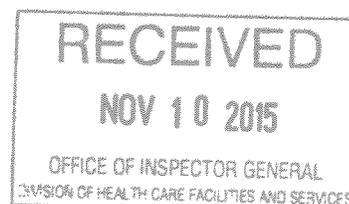
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F 282	<p>Continued From page 14 occasional incontinence of urine.</p> <p>Interview with the family of Unsampled Resident A, on 10/14/15 at 11:30 AM, revealed the resident had an odor of urine and had a heavy stubble of hair. She stated the resident looked uncared for often when she visited. She stated she had requested the resident be bathed two (2) to three (3) times per week and shaved daily several weeks ago. She stated the request was not honored and the facility had made no attempt to provide the care as she requested.</p> <p>Interview with CNA #6, on 10/14/15 at 3:50 PM, revealed Unsampled Resident A did need a bath and a shave. She stated the resident did not often refuse bathing or shaving and more than one (1) person might have to ask the resident; however, the resident smelled like urine and had a heavy growth of facial hair. She stated she did not have access to the resident's comprehensive care plan. She stated she was not aware of when the resident was last bathed or shaved.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 10/15/15 at 10:06 AM, revealed Unsampled Resident A did need routine bathing and shaving. She stated she tried to keep up with residents and pass medications as well. She stated she reviewed the resident's comprehensive care plan and there was no specific information on what to do for the resident so the staff was to do all care. She stated she was not aware the resident's family requested the resident receive a daily shave. She stated the resident was to receive a bath two (2) times a week. She stated the resident needed encouragement and patience to bathe and shave and should not smell of urine or have that much facial hair.</p>	F 282	<ul style="list-style-type: none"> • Appropriate grooming to include hair and clothing <p>4. The Director of Nursing/Assistant Director of Nursing will complete an audit of 5 random residents weekly for 3 months, then randomly to ensure residents are being bath and shaved according to their plan of care as well as being groomed appropriately with hair combed and clean clothing. Any discrepancy in the audit will be corrected at that time by offering the resident a shower or a shave separate from the chosen schedule. Results of the audits will be submitted monthly to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for its review and recommendation. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.</p>	



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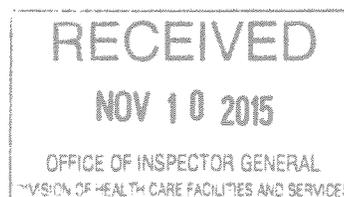
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F 282	Continued From page 15	F 282		
F 312 SS=D	<p>Interview with the Director of Nursing, on 10/15/15 at 2:40 PM, revealed staff should follow the care plan and if unable to follow the care plan, they should report this to the manager. She stated the staff needed to follow the care plan for resident care.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined the facility failed to provide the necessary bathing and shaving to maintain a resident's highest practicable physical and mental well-being for one (1) of fourteen (14) sampled residents and eleven (11) unsampled residents, (Unsampled Resident A). Unsampled Resident A smelled of urine on multiple occasions and had a heavy stubble of facial hair.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding bathing and grooming to ensure the residents had the highest physical and mental well-being.</p> <p>Review of Unsampled Resident A's clinical record, revealed the facility completed a quarterly MDS assessment for the resident, on 09/01/15,</p>	F 312	<p>It is the practice of this facility when a resident is unable to carry out activities of daily living to provide the necessary services to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>1. Resident A has been a resident since 2004. He has agreed to a shower and a shave following survey exit. He continues to refuse showers 3 times per week, and refuse offers by staff for daily shaves at times. He states he "will not be shaved every day" and he "will not be showered three times a week". Each time he refuses, the family is notified. Facility has requested the family to come to facility and assist with coaxing resident to shower and/or shave. The family has not been back to facility to assist with coaxing. On 11/6/15 Director of Nursing and Administrator asked resident why he has been refusing showers and</p>	11/28/15



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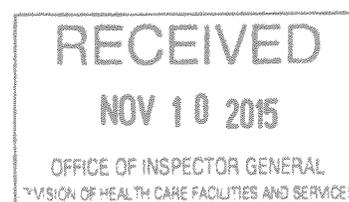
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F 312	<p>Continued From page 16</p> <p>which revealed the resident had a fifteen (15) out of fifteen (15) score on the Brief Interview for Mental Status and was able to be interviewed</p> <p>Observation of Unsampled Resident A, on 10/13/15 at 4:10 PM, revealed the resident was disheveled in appearance and had the faint smell of urine, and a heavy stubble of facial hair. The resident had on clothing and a jacket with frayed sleeve edges and stains. The resident was in a wheelchair and had the left arm curled into his/her lap. The resident's hair was sticking up and had not been combed.</p> <p>Observation of Unsampled Resident A, on 10/14/15 at 5:40 PM, revealed the resident had a strong smell of urine and heavy facial hair stubble.</p> <p>Interview with Unsampled Resident A, on 10/14/15 at 11:40 AM, revealed there was no smell that he/she could tell and stated no bath had been received for over a week. The resident stated shaving was completed daily prior to coming to the nursing home; however, that had been completed many days ago and no one had offered to assist with shaving since.</p> <p>Interview with the resident's family member, on 10/14/15 at 11:30 AM, revealed the resident frequently smelled of urine and needed a shave. She stated she requested the resident receive a bath three (3) times a week and a shave daily several weeks prior. She stated the request was ignored by the facility and it did no good to ask for better care.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 10/14/15 at 3:50 PM, revealed the resident was</p>	F 312	<p>shaves and he said "it doesn't matter what his daughter wants, it matters what he wants." We asked resident how often he wanted to be showered and he said twice a week. We asked resident how often he wants to be shaved and he said only on shower days. Director of Nursing educated resident on importance of daily care and hygiene. The care plan has been reviewed and updated to reflect resident behaviors and self-determination.</p> <p>2. The Assistant Director of Nursing on 10/15/15 and 11/6/15 conducted an audit of resident scheduled shower days and times, and update the shower schedule according to resident preferences. Care plans will be updated according to resident shower preferences for days and shifts. The C N A care plan (accu nurse) will be updated by the Assistant Director of Nursing to include cueing the C N A to record completion of grooming and showers.</p> <p>3. The Director of Nursing on 10/27/15 completed an educational review for the nursing staff regarding:</p>		



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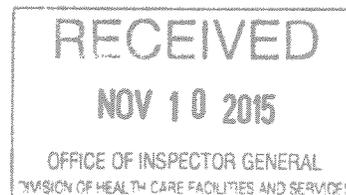
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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F 312	Continued From page 17 supposed to be bathed three (3) times a week and as needed. She stated smelling like urine required a bath and the resident needed a shave as the facial hair was heavy. She stated the resident was more cooperative when a bath was arranged with the resident. She further stated she had no access to the comprehensive care plan and was not sure what that was. Interview with the Licensed Practical Nurse (LPN) #4, on 10/15/15 at 10:06 AM, revealed the resident needed a bath when they smelled of urine and a shave when a beard started to show. She stated she was the supervisor for the CNAs and tried to monitor resident's to ensure care was received. Interview with the Director of Nursing, on 10/15/15 at 2:40 PM, revealed she was not aware of Unsampled Resident A's hygiene issues. She stated nursing staff were to report if a resident was refusing bathing or other hygiene and she was not notified regarding the resident.	F 312	<ul style="list-style-type: none"> the regulation F 312 as it relates to provision of care (to include showers and shaving) and following the care plan C N A notification to the charge nurse if the resident refuses care / showers and shaving Appropriate grooming to include hair and clothing 	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356	4. The Director of Nursing/ Assistant Director of Nursing will complete an audit of 5 random residents weekly for 3 months, then randomly to ensure residents are being bath and shaved according to their plan of care as well as being groomed appropriately with hair combed and clean clothing. Any discrepancy in the audit will be corrected at that time by offering the resident a shower or a shave separate from the chosen schedule. Results of the audits will be submitted monthly to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT	



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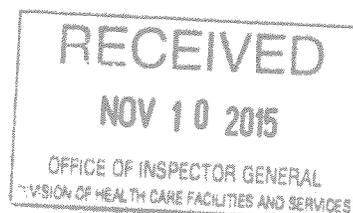
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F 356	<p>Continued From page 18</p> <ul style="list-style-type: none"> o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to post nurse staffing information that included the total number and the actual hours worked by licensed and unlicensed nursing staff involved in direct resident care for three (3) of three (3) survey days, (10/13/15, 10/14/15, and 10/15/15).</p> <p>The findings include:</p> <p>Interview with the Administrator, on 10/15/15 at 3:30 PM, revealed the facility did not have a policy regarding the required posting of licensed and unlicensed staff hours.</p> <p>Observation of the posted Daily Staffing Sheets for the days of 10/13/15, 10/14/15, and 10/15/15,</p>	F 356	<p>committee for its review and recommendation. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.</p> <p>F 356 It is the practice of this facility to post nurse staffing information daily which includes the facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.</p> <ol style="list-style-type: none"> 1. On 10/16/15 the nurse staffing information sheet was updated to include total number and the actual hours worked by licensed and unlicensed nursing staff involved in direct resident care. 2. The Administrator completed an audit on 10/19/15 to confirm that the total number and actual number of 	11/28/15



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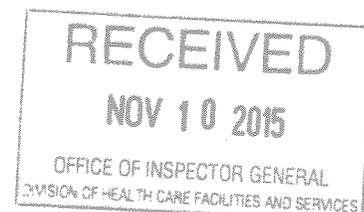
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F 356	Continued From page 19 on 10/15/15 at 5:15 PM, revealed the facility posted a list of the number of nurses and nurse aides working. The postings did not include the total and actual hours worked by licensed and unlicensed staff. Interview with the Director of Nursing (DON), on 10/15/15 at 4:25 PM, revealed she and the Assistant Director of Nursing (ADON) were responsible for posting the Daily Staffing Sheets. She stated she was unaware of the posting requirement for the total and actual work hours of licensed and unlicensed staff.	F 356	unlicensed nursing staff involved in direct resident care are being posted correctly. 3. The Director of Nursing on 10/27/15 conducted an educational review for licensed nurses on F 356 as it relates to completion and posting of the required staffing form. 4. The Administrator will conduct an audit of the Nurse staffing posting weekly for 1 month, twice monthly for 1 month followed by monthly for 3 months to ensure the form is being completed and posted correctly. Any discrepancy noted during the audit will be corrected at that time. Results of the audits will be submitted monthly to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for its review and recommendations. If at any time concerns are identified the committee will convene to review and make further recommendations as needed.	
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide a food alternate/substitute of similar nutritive value for two (2) of fourteen (14) sampled residents and eleven (11) unsampled residents (Unsampled Residents F and H). The facility failed to provide a substitute for broccoli at the lunch meal. The resident were not informed of the food alternatives/substitutes for lunch served on 10/14/15 and a vegetable alternative/substitute was not available. In addition the alternatives/substitutions were left-overs from 10/13/15. The findings include:	F 366		



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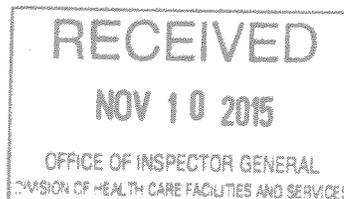
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F 366	Continued From page 20 Review of the facility's policy titled Menus, not dated, revealed if a food group was missing from the resident's daily diet, the residents would be provided with an alternative means of meeting the resident's nutritional needs. The facility policy also stated menus were dated and posted one (1) week in advance. The facility policy further stated the Resident Council would be included in periodic menu planning and that any deviation from the posted menus would be noted to include the reasoning for the substitution/deviation in the record book used for recording such changes by the dietary staff. These substitutions would be ready and on the steam table. Review of a Resident Concern Form, dated 08/18/15, revealed that a resident stated in the Resident Council meeting that they would like to have something other than soup and sandwiches for supper and they also would like a variety of soups instead of tomato and vegetable soups. Observation, on 10/14/15 at 10:35 AM, revealed the food items on the steam table for lunch contained beef stroganoff with noodles, seasoned broccoli, and whole wheat rolls. The staff was observed serving sliced ham enclosed in clear wrap and potatoes emerged in water in a clear bowl as the alternate/substitute food for the beef stroganoff with noodles and seasoned broccoli. Review of the Menu Diet Spreadsheet for the lunch meal on 10/14/15 revealed the hot item menu specified beef stroganoff with noodles, seasoned broccoli, and whole wheat rolls were to be served as the hot food items. The menu diet spreadsheet for the lunch meal on 10/14/15. The alternative/substitute food item for the beef	F 366	F 366 It is the practice of this facility that each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. 1. A substitute of similar nutritional value was offered on 10/14/15 and posted. 2. The dietary manager will hold a monthly food committee meeting with residents to review the menu, voice their concerns and bring forward suggestions. The dietary manager is posting the daily menu to include the main course as well as the substitute meal. Additionally it is announced overhead daily on the intercom with instructions for the residents to let their C.N.A. know if they would like the substitute meal. The dietary manager will be ensuring daily that substitutes of similar nutritive value are being provided. 3. The Director of Nursing on 10/27/15 provided C.N.A.'s with education regarding resident requesting and receiving the substitute meals. The Dietary Manager provided education to	11/28/15



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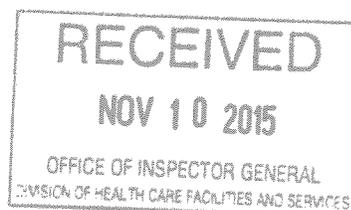
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F 366	<p>Continued From page 21</p> <p>stroganoff with noodles and seasoned broccoli was sliced ham and a baked potato.</p> <p>Interview with Unsampled Resident F, on 10/15/15 at 3:13 PM, revealed the posted substitute/alternative food items on the menu were often changed thirty (30) minutes before it was time to be served the meal. Continued interview with Unsampled Resident F revealed he/she was not offered a substitute for lunch that day. In addition, substitutes were often leftovers from meals the previous day.</p> <p>Interview with Unsampled Resident H, on 10/14/15 at 12:25 PM, revealed he/she was not offered a choice of what to eat for lunch that day. In addition, he/she stated the facility serves whatever they want for lunch and dinner and had never offered him/her a meal substitute.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 10/15/15 at 1:45 PM, revealed there had been complaints from residents about not liking the food. CNA #1 stated the residents complained about having to eat left overs. CNA #1 stated she had talked to the dietary staff about the concerns and was told that corporate made the menu and that the kitchen had nothing to do about the left over food. CNA #1 stated she found that a lot of times what was on the menu, the kitchen did not have.</p> <p>Interview with CNA #2, on 10/15/15 at 1:50 PM, revealed she witnessed the kitchen staff saying things like they do not have the alternative food item or that there was not enough food to provide the alternate food item. CNA #2 stated there was no system in place to ask the residents about</p>	F 366	<p>dietary staff on 11/3/15 on planning substitute meals of similar nutritional value.</p> <p>4. The regional Dietician will review the menu twice a month for 1 month and once a month for 5 months to ensure substitutes of similar nutritive value are being offered. Any discrepancy in the audit will be corrected at that time. Results of the audits will be submitted to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT Committee monthly for six months for its review and recommendations. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.</p>	



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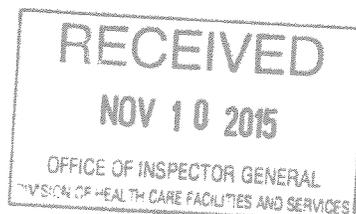
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F 366	<p>Continued From page 22 their meal choices for the day.</p> <p>Interview with the Dietary Manager (DM), on 10/14/15 at 3:39 PM, revealed the facility did not offer a selective menu to the residents and if the residents wanted to know what food items were being offered for the day, they would have to come and look at the menu in the hall outside the dinning room that was posted everyday at 5:30 AM. The DM stated the alternative/substitute meal offered to the residents for the day was usually the left-overs from the previous day, if they had enough, that's the reason why they posted the menu in the hall outside the dining room on a day-by-day basis. The DM also stated that the residents who were not ambulatory would not have information regarding the substitutions until the CNAs delivered their tray in their room.</p> <p>Review of the Dietary Spreadsheet, revealed an alternate menu was not prepared by the Dietician.</p> <p>Further interview with the DM, on 10/15/15 at 10:14 AM, revealed after the trays were served to the residents and the resident stated they didn't like what was served to them; the CNA would return the tray to the dietary staff and request something different for the resident. If they had it, they would honor the request that was made by the resident.</p> <p>Interview with the Registered Dietitian (RD), on 10/14/15 at 3:47 PM, revealed the alternative/substitute meal for lunch should have been prepared and ready to serve from the steam table, along with the regular meal that was already prepared and on the steam table for the day. The RD stated that a baked potato did not</p>	F 366			



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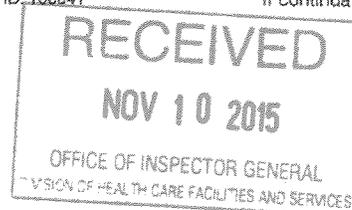
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F 366	Continued From page 23 offer the same nutrients as broccoli did and a baked potato should not have been offered as the alternative/substitute for the broccoli. The RD also stated a vegetable was the only substitute for another vegetable. The RD further stated the reason nutritious meals were provided to residents was to keep them healthy so they could have good quality of life by maintaining their weight and skin integrity. Interview with the Cook #2, on 10/14/15 at 4:04 PM, revealed the ambulatory residents usually came to the open kitchen window inside the dining room to request an alternate food if they didn't like the food items that were served to them. Cook #2 stated the dietary staff were not informed if a resident had chosen a alternative or substitute food item prior to the meal. Interview with the Administrator, on 10/15/15 at 11:14 AM, revealed she was unaware of any resident complaints regarding their preference of food items served by the dietary staff. The Administrator stated not all of the residents were ambulatory and they were not able to look at the posted menu items in the hall outside the dining room. The Administrator also stated the substitute menu items of equal nutritional value were not listed on the facility's therapeutic menu. The Administrator further stated that left-overs were served often because food costs were one of the highest costs budgeted in the nursing homes.	F 366			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369	It is the practice of this facility to provide special eating equipment and utensils for residents who need them.	11/28/15	



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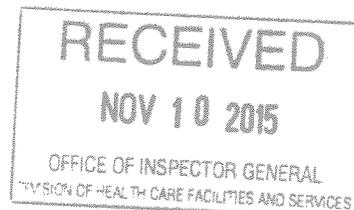
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F 369	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the resident's dietary cards, it was determined the facility failed to provide assistive eating devices to three (3) of fourteen (14) sampled residents and eleven (11) unsampled residents eating in the dining room, (Unsampled Residents A, J and K), on 10/14/15 at 11:10 AM. The findings include: The facility did not provide a policy regarding provision of assistive eating devices to residents. 1. Observation of Unsampled Resident J, on 10/14/15 at 11:10 AM, revealed the resident had two (2) drinks in sippy cups and one (1) drink in a glass. The resident had fine and coarse tremors in both hands. The resident made one (1) attempt to lift the glass just barely and dropped the glass back to the table. Review of the dietary card for Unsampled Resident J, revealed the resident required sippy cups for all fluids at mealtime. Interview with Licensed Practical Nurse (LPN) #4, on 10/14/15 at 12:10 PM, revealed Unsampled Resident J spilled fluids if they were not in a cup with a lid. She stated the resident had constant tremors in both hands. 2. Observation of Unsampled Resident K, on 10/14/15 at 11:16 AM, revealed the resident was served three (3) glasses of fluids and no sippy cups. The resident's hands were unstable while	F 369	1. During the survey, resident A was provided with a divided plate. Resident J and K were provided with spout cups on 10/15/15. 2. Occupational therapy screened residents between the dates of 10/27/15-11/5/15 with current orders for equipment or assistive eating devices to determine if they still have a need for the equipment or devices. The therapy representative will then provide a list of equipment need for those residents' to the Dietary Manager. The Dietary Manager will review the accuracy of the resident's dietary card and update accordingly. 3. The Director of Nursing on 10/27/15 provided an educational review for nursing staff on the importance of checking the meal card to verify that it matches the meal served and that assistive eating devices/equipment is in use. The Administrator on 11/4/15 provided educational review for department heads on the importance of checking the meal card to verify that it matches the meal served and that assistive eating devices/equipment is in use. The Dietary Manager on	



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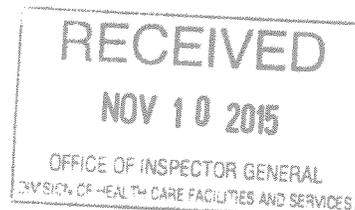
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NAME OF PROVIDER OR SUPPLIER HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 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 369	<p>Continued From page 25</p> <p>holding the glass and staff assistance was required.</p> <p>Review of the dietary card for Unsampled Resident K, revealed the resident required sippy cups at all meals.</p> <p>Interview with LPN #4, on 10/14/15 at 12:10 PM, revealed Unsampled Resident K spilled fluids due to poor coordination and lack of muscle control.</p> <p>3. Observation of Unsampled Resident A, on 10/14/15 at 11:40 AM, revealed the resident's food, noodles and beef, were served on a regular plate. The resident attempted to use a spoon to capture the food, however, the resident was not successful.</p> <p>Review of the dietary card for Unsampled Resident A, revealed the resident required a divided plate.</p> <p>Interview with LPN #4, on 10/14/15 at 12:10 PM, revealed the resident had weakness in one (1) arm and was unable to get the food onto a spoon without the plate dividers.</p> <p>Interview with a family member of Unsampled Resident A, on 10/14/15 at 11:43 AM, revealed the resident was not able to eat unless the food was in a divided plate.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 10/14/15 at 12:25 PM, revealed the nursing staff delivering the trays in the dining room should have read the diet card and requested the sippy cups and the divided plate from the kitchen. She stated she did not know why the assistive devices were not requested. She stated the residents</p>	F 369	<p>11/3/15 provided an educational review for dietary staff on the importance of checking the meal card to verify that it matches the meal they have served and that assistive eating devices/equipment is in use</p> <p>4. The Dietary Manager will audit all the meal cards of residents who have assistive eating devices 5 days a week for 2 weeks, then 3 days a week for 2 weeks then weekly for 1 month then monthly for 5 months to ensure residents are receiving the correct adaptive equipment/assistive eating devices. Any discrepancy noted during the audit will be corrected at that time. Results of the audits will be submitted monthly to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for its review and recommendations. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director, attending at least quarterly.</p>	



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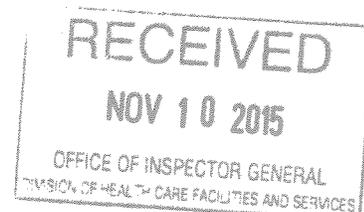
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/15/2015
NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143		
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F 369	Continued From page 26 were able to be more independent if fluids were in cups they could lift and drink from. Interview with the Dietary Manager, on 10/15/15 at 10:20 AM, revealed the kitchen had enough sippy cups and she had no reason for some residents not getting sippy cups on the meal trays. She stated nursing should have reviewed the diet cards and requested the sippy cups. She stated the kitchen missed the divided plate for Unsampled Resident A. She stated these assistive devices helped residents feed themselves better.	F 369			
F 371 SS=F	Interview with the Administrator, on 10/15/15 at 11:04 AM, revealed residents used assistive devices to be more independent at mealtime. 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 distribute food under sanitary conditions when	F 371	It is the practice of this facility to (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. 1. The Dietary Manager completed an immediate audit of plates and bowls to ensure food was not being served on wet plates or in wet bowls. The dietary manager had the ice scoop run through the dishwasher and it placed in a bag with the current date. 2. The dietary staff will serve food under sanitary conditions. A plastic ice scoop holder was ordered on 10/30/15 and installed on 11/5/15.	11/28/15	



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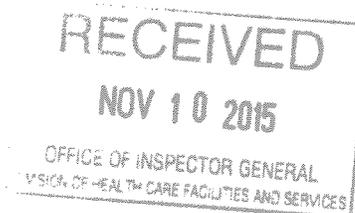
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F 371	<p>Continued From page 27</p> <p>serving food during the meal service on 10/14/15 at 10:35 AM. The Cook placed food from the steam table onto a wet plate and a divided wet plate. The stack of plates and divided plates were stored bowl side up and delivered to the tray line carts during the lunch meal on 10/14/15. In addition, the facility failed to ensure the ice scoop used in the dining room was stored in a sanitary manner.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Sanitation and Infection Control, not dated, revealed the dietary staff were to allow all racks of washed dishes to thoroughly dry prior to stacking the dishes for use.</p> <p>Review of the facility policy for Ice Machines and Ice Storage Chests, not dated, revealed the ice scoop was covered in a bin and the scoop was cleaned and sanitized daily.</p> <p>1. Observation, on 10/14/15 at 10:45 AM, during the lunch tray line revealed Cook #2 took a wet plate from a stack of plates that were stored bowl side up in the plate warmer and placed food onto the plate then placed the plate of food on a tray for a resident.</p> <p>Observation, on 10/14/15 at 10:51 AM, during the lunch tray line revealed Cook #2 took a wet divided plate from a stack of divided plates that were stored facing bowl up on a shelf above the steam table and placed food onto the plate then placed the plate of food on a tray for the residents.</p> <p>Interview with Cook #1, on 10/14/15 at 3:50 PM,</p>	F 371	<p>3. The Dietary Manager on 11/3/15 provided an educational review for dietary staff on F 371 as it relates to kitchen sanitation to include: wet nesting, not serving food on wet plates, storing plates bowl side down and on cleaning the ice scoop and storing it with current date.</p> <p>4. The Dietary Manager will monitor the food service tray line daily, 5 days per week for 2 weeks, then 3 days per week for 2 weeks then weekly for 4 weeks, then monthly for 3 months to verify that dishes are not wet and food is not being placed on wet plates or in wet bowls. This audit will be conducted during breakfast, lunch and dinner meals. The Dietary Manager will monitor that the ice scoop is being cleaned and sanitized daily, 5 days per week for 2 weeks, then 3 days per week for 2 weeks then weekly for 4 weeks, then monthly for 3 months. Results of these audits will be submitted to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee monthly for its review and recommendation. Any discrepancy noted in the audit will be corrected at that time. If at any time</p>	



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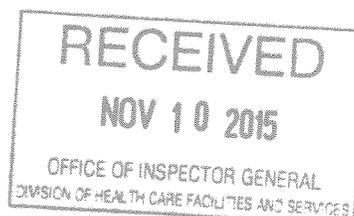
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F 371	<p>Continued From page 28</p> <p>revealed when she was serving food from the steam table and the plate she had picked up was wet she would dry it off with a towel before she served it because a wet plate would water down the food and take the flavor of the food away. Cook #1 stated she had a training class at the local health department on cross-contamination and sanitation.</p> <p>Interview with Cook #2, on 10/14/15 at 4:04 PM, revealed she would not have served a resident from a wet plate because a wet plate could have bacteria on it from standing water and serving from a wet plate was a violation of the cross-contamination rules. Cook #2 stated if a resident ate food from a plate that was contaminated with bacteria it would make them sick. Cook #2 stated she did not realize she had served the residents from the wet plates because she tried to set all the wet plates to the side to be re-washed in the dish washer. Cook #2 stated she was a little frustrated with the staff confusion at the kitchen window and wasn't aware that she had served from wet plates.</p> <p>Interview with the Dietary Manager (DM), on 10/15/15 at 11:40 AM, revealed the facility policy stated to allow dishes and utensils to completely dry before stacking and use. The DM stated the dietary employees were trained and certified by the local health department and that she gave in-services throughout each year on the policy which included air drying dishes. The DM also stated the potential harm for using wet dishes would be bacteria growing on the dishes and making the residents ill.</p> <p>2. Observations of the dining room, on 10/13/15</p>	F 371	<p>concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.</p>	



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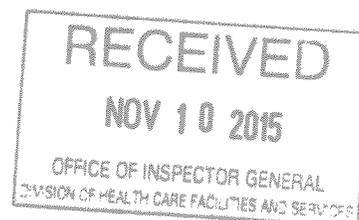
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F 371	Continued From page 29 at 9:48 AM, 10/14/15 at 1:48 PM and on 10/15/15 at 11:05 AM, revealed an ice scoop in a plastic bag resting on top of the ice machine. The plastic bag had water inside and the scoop sat in the water. The plastic bag was dated 10/12/15. Interview with Certified Nurse Aide (CNA) #5, on 10/15/15 at 8:30 AM, revealed the ice scoop located on the ice machine in the dining room, was used at each meal to add ice to residents' drinks. She stated the ice scoop was taken to the kitchen and cleaned every day. She stated she did not look at the date on the storage bag and it should be today's date. She stated residents could get sick from bacteria grown in the water in the storage bag. Interview with the Director of Nursing, On 10/15/15 at 11:05 AM, revealed the ice scoop was not to be stored in a plastic bag. She stated the ice scoop was to be stored in a clean dry container. She stated residents could become ill from bacteria growth on the scoop and in the water.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	It is the practice of this facility to ensure that emergency medical supplies are not expired 1. The Sterile Water was replaced on 10/15/15. Disposable Inner Cannula was discarded because item does not need to be on crash cart. Two Suction Catheters were on the crash cart the expired one was discarded.	11/28/15



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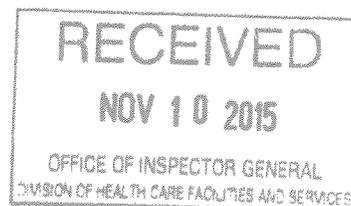
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F 431	<p>Continued From page 30</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</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 emergency medical supplies were not expired on one (1) of two (2) crash carts.</p> <p>The findings include:</p> <p>Observation of the crash cart on the West Hall, on 10/15/15 at 10:20 AM, revealed Sterile Water expired on March 2015, Disposable Inner Cannula expired November 2012 and Suction Catheter expired May 2015.</p>	F 431	<p>2. The Director of Nursing completed an audit on 10/15/15 to ensure both crash carts did not have any expired equipment on them. Expired equipment evaluation was added to the crash cart check off list on 10/15/15.</p> <p>3. The Director of Nursing on 10/17/15 provided an educational review regarding F 431 as it relates to the crash cart and checking the crash cart for supplies/and dates of expiration.</p> <p>4. The Director of Nursing/ Assistant Director of Nursing will audit the crash cart weekly for 4 weeks, then monthly for 3 months to validate that the supplies listed are not outdated. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee monthly for its review and recommendations. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at minimum the Director</p>



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F 431	Continued From page 31 Review of the Crash Cart Check off list, for the months of September and October 2015, revealed there was no evidence the staff was checking for expired equipment. Interview with Licensed Practical Nurse (LPN) #2, on 10/15/15 at 1:55 PM, revealed the night shift nursing staff checked the crash carts. LPN #2 stated she only checked the crash cart for the items on the Crash Cart Check off list. The check off list only asks for items present, not for items that could be expired. LPN #2 stated the residents could sustain serious injury if the expired equipment were not functioning. Interview with the Assistant Director of Nursing (ADON), on 10/15/15 at 10:33 AM, revealed she had checked the crash carts for items to ensure they were present, but not for expiration dates. The ADON stated the residents care could be affected. Interview with the Director of Nursing (DON), on 10/17/15 at 11:30 AM, revealed she had not looked at the crash carts at all and that her or the Assistant Director of Nursing should of been checking them. The DON stated she wanted items to be functioning because something terrible could happen and the equipment could malfunction.	F 431	of Nursing, Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director attending at least quarterly.		



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NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 11/28/15 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2015
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967, 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; hydraulically designed.</p> <p>GENERATOR: Type II, 55 KW generator; fuel source is propane gas; installed new in 2009.</p> <p>A Recertification Life Safety Code survey utilizing the 2786S Short Form was conducted on 10/13/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	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.