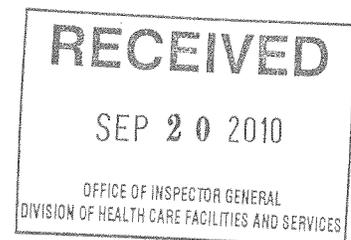


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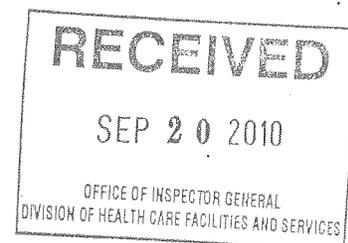
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2010
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006		
(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 272	Continued From page 12 observed. Review of the clinical record for Resident #3 revealed the resident was admitted to the facility with diagnoses of Dementia and Hypertension. The facility completed an admission MDS assessment on 07/26/10 which revealed the resident had a moderate impairment in the ability to make daily care decisions with long and short term memory deficits. The resident required extensive assistance with dressing, mobility, and hygiene. The resident received an antipsychotic medication for mood and behavior. The MDS RAP for Antipsychotics indicated the resident was noncompliant (would transfer without assistance) and was agitated at times. There was no evidence the facility assessed the resident's agitation for the cause or identified or quantified what behaviors occurred during agitation. In addition, the dietary notes revealed the resident had experienced a significant weight loss in the last six months and the resident received a memory enhancing medication with the side effect of loss of appetite. 3. Review of the clinical record for Resident #4 revealed the resident was admitted to the facility on 01/20/10 with diagnoses of Schizophrenia, Congestive Heart Failure, Hypertension, Coronary Artery Bypass Graft x4, Venous Thrombosis and Pneumonia. The facility completed an admission Minimum Data Set (MDS) assessment on 07/09/10 which revealed the resident had a cognitive score of two (2) in the ability to make daily care decisions with long term memory deficits. The resident received an anti-psychotic medication for mood and behavior, which included Paroxetine daily and Cogentin twice daily. The MDS reported medication adjustments	F 272			



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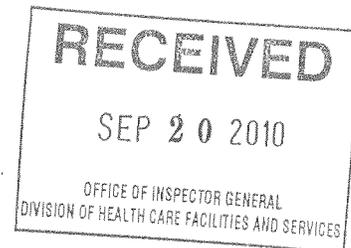
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F 272	Continued From page 13 were done. The MDS did not identify any behaviors, and the Behavior Monitoring Flow Record and the Certified Nurse Assistant Flowsheet was blank. Interview with the MDS Coordinator on 08/25/10 at 2:30pm revealed the purpose of the RAP was to assess the triggered area. She stated specific behaviors should be identified and the progress or lack of progress should be assessed. She offered no reason for not utilizing the required MDS RAPs when an area triggered. Interview with the Director of Nursing on 08/23/10 at 3:30pm revealed she was not aware the MDS RAPs were not utilized to further assess triggered areas; however the RAPs were to be used as required.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F 279 1. Resident #2 was assessed by the MDSC and the Social Services Director on 9/22/10 for specific behaviors and the need for anti-anxiety medications. Resident #2 was reassessed using the MDS process and a comprehensive plan of care was developed to appropriately manage the resident's specific behaviors. 2. A comprehensive care plan audit will be completed by the MDSC on 9/24/10 on all residents to ensure that residents are assessed for specific behaviors and psychoactive and anti-anxiety medications; a comprehensive plan of care will be completed per regulation to include measurable objectives and timetables to meet each residents medical nursing and mental and psychosocial needs as they are identified. 3. The Regional Nurse Consultant will educate the DON, ADON,	9/23/10



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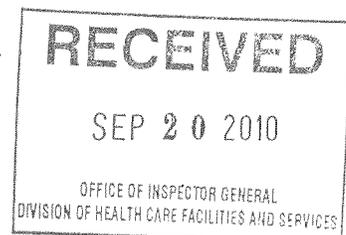
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F 279	<p>Continued From page 14</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to use the results of the assessment to develop quantifiable comprehensive care plan objectives for the highest level of functioning the resident may be expected to attain for one (1) of fifteen (15) sampled residents (#2). Resident #2 received an anti-anxiety medication and there was no evidence specific behaviors were identified and care planned.</p> <p>The findings include:</p> <p>The facility used the Resident Assessment Instrument (RAI) Manual 2.0 for their care plan policy. The facility used Resident Assessment Protocol (RAP) information to develop individualized care plans based on identified needs, strengths and preferences of the resident.</p> <p>Observations of Resident #2 on 08/23/10 at 11:05am, 12:30pm, 2:30pm, 3:00pm, and on 08/24/10 at 8:30am, 9:15am, 9:30am, 11:20am, and 2:30pm, revealed the resident was awake and quiet. No behaviors were observed.</p> <p>Review of the clinical record for Resident #2 revealed the resident was admitted to the facility with diagnoses of Dementia with Behavior, Personality Disorder, and Head Injury. The facility completed an annual Minimum Data Set (MDS) assessment on 06/03/10 which revealed the resident had a severe impairment in the ability</p>	F 279	<p>MDSC and Social Service Director on identifying specific behaviors, the need for psychoactive and anti-anxiety medications and behavioral care plans. A process has been implemented to appropriately identify resident's specific behaviors and to ensure that these behaviors are care planned accordingly.</p> <p>4. The Director of Nursing / ADON will audit 20% of resident records monthly to ensure that residents comprehensive assessments reveal measurable objectives and timetables to meet each residents medical nursing and mental and psychosocial needs. Results of this audit will be forwarded to the quarterly QA meeting for six months; for recommendations and further follow up as indicated.</p>		



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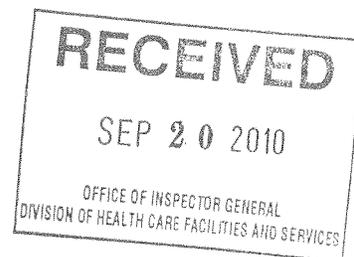
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F 279	Continued From page 15 to make daily care decisions. The resident required total assistance for all care needs. The resident received an anti-anxiety medication.	F 279			
F 371 SS=E	Review of the care plan revealed no evidence the facility addressed any specific behaviors for Resident #2's use of an anti-anxiety medication. Interview with the MDS Coordinator and the Social Service Director on 08/25/10 at 2:30pm revealed Resident #2 had anxiety on the care plan; however, specific behaviors had not been identified. They offered no reason for the specific behaviors not being identified and addressed. 483.36(l) 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 store, prepare, distribute, and serve food under sanitary conditions. Opened and undated items were observed in the refrigerators, food preparation equipment was soiled, cleaning of surfaces was hindered by paper signs secured with tape, plates were stored and ready for use; however, the plates were wet.	F 371	F 371 1. The Dietary Manager discarded any food items that were identified as not being properly stored, not dated on time of opening and cleaned all areas identified as unsanitary. The dishes were evaluated for sanitary conditions. The dishes were air dried before they were stored and ready for use. All paper signs and tape were removed to ensure all surfaces are cleaned. 2. The Dietary Manager completed an audit of the food storage area and kitchen on 9/21/10. All food items not stored per regulation, not dated when opened were discarded, all areas determined to be unsanitary per regulation was immediately cleaned and sanitized. 3. The Dietary staff was educated by the Registered Dietician on 9/20/10 regarding food items stored appropriately, all food items must be dated when opened and if not, the items must be discarded. Staff was educated on the proper sanitary conditions and cleaning methods for	9/28/10	



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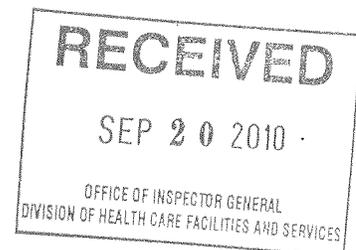
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F 371	Continued From page 16 The findings include: Review of the facility policy for Sanitation, undated, revealed the kitchen should be a sanitary environment for food. Observation of the kitchen during the initial tour, on 08/23/10 at 8:45am, revealed opened and undated foods in the refrigerator. Lettuce was uncovered; cheese, cookie batter and french fries were opened and undated. The outside of the coffee maker was smeared, had dried drips and the white opening on the top had a heavy build-up of brown residue. Observation of the kitchen on 08/25/10 at 1:45pm revealed a container of dried cloves expired May 2010. The outside of the deep fryer was smeared with a large quantity of an oily looking substance. A two (2) shelf cart located next to the fryer had oily smears and dried particles and substances on the shelves. The cart contained food items and supplies. The three (3) compartment sink had a heavy build-up of a white substance all around the sinks, the seams and the faucets. A paper sign was taped to the front of the paper towel dispenser at the hand sink. The sign had multiple layers of tape which were pulling apart and curling up. Brown and white particles were embedded in the tape. The outside of the dispenser was smeared. The outside of the mop bucket had a heavy build-up of ground-in gray substances. The meat slicer was uncovered and bits of meat and brown particles were observed on the cutting blade. The toaster levers were sticky and covered with brown particles. Plates ready for use were stacked, on the side of the steam table, wet and the plate cart covers were	F 371	all equipment, and sanitation of the department. The Dietary Manager / Cook will complete a daily audit of the food storage areas and the kitchen to ensure that food products are stored and dated properly and discarded when necessary. The dietary manager /cook will also complete a daily audit of the food storage areas and kitchen to ensure a sanitary environment. The department will not utilize paper signs posted with tape in the department. 4. The Dietary Manager/Cook will forward the daily results of the food storage audits and sanitization audits for review to the monthly infection control meeting. All recommendations and results will be forwarded to the quarterly QA meeting for six months for recommendations and further follow up as indicated.		



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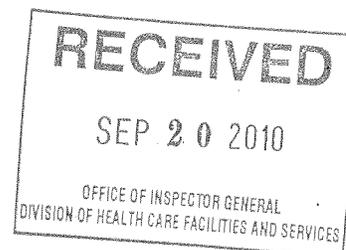
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F 371	Continued From page 17 observed to have brown and white particles in the crevices. Interview with the Dietary Manager (DM) on 08/25/10 at 1:45pm revealed she was responsible for supervising the kitchen staff that performed the cleaning tasks. The DM stated plates were not to be stacked until they were dry. She stated the deep fryer, carts, three (3) compartment sinks, paper towel dispenser, toaster, and coffee machine were cleaned on a weekly basis. The DM stated all tables and shelves were to be wiped down each day and the toaster was to be wiped at the end of the shift. She stated the meat slicer was to be cleaned after each use then covered. In addition, she stated the mop bucket could be scrubbed and made clean and indicated the kitchen staff were to go over the areas as they performed their jobs.	F 371	F 431 1. The six identified medications that did not contain an opened date or were not labeled in accordance with currently accepted professional principals were discarded per protocol. The two medications that remained on the cart after they had been discontinued were removed. The pharmacy was notified to replace the six discarded medications 2. A medication audit was completed by the Director of nursing 9/19/10 of all medication's regarding the open date, discontinued medications, and appropriate labeling of all medications. The medication carts and the treatment carts for East and West wing were audited. Any medications that did not contain the appropriate opened date were immediately discarded. The Pharmacy was notified to replace the discarded items with no charge to the resident. All medications that were discontinued were discarded per protocol.	
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 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		9/28/10



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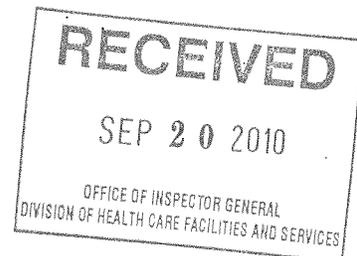
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F 431	<p>Continued From page 18</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately 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 the facility failed to ensure the drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, expiration date when opened and failure to remove discontinued medications. Two (2) medications, Miralax and Guaifenesin DM Syrup, remained on the medication cart after they had been discontinued by the physician. Six (6) liquid medications had been opened and not labeled with the open date; Potassium Chloride liquid, Reglan liquid, Carafate slurry, Robitussin DM liquid, Phenytoin Suspension, and Chloraseptic liquid spray.</p> <p>The findings include: Record review of the facility's policy for Medication Administration Review of Medication, undated revealed the drug regimen review</p>	F 431	<p>3. Licensed Nursing Staff and Certified Medication Aides were in-serviced by the Director of Nursing on 9/17/10 regarding Drug Records, Label/ Store Drugs and Biological. Education consisted of protocols for liquid medications must be dated when they are opened and any discontinued medication must be removed from the medication cart in an appropriate time frame and discarded per professional protocol. The Assistant Director of Nursing will complete a weekly review of each medication and treatment cart to ensure the biological used in the facility are labeled with accepted professional principals and includes the appropriate accessory and cautionary instructions and the expiration date when applicable. And all discontinued medications are removed.</p> <p>4. The Assistant Director of Nursing will forward the results of the weekly audit to the weekly At Risk Meeting for review and follow up recommendations. Results and recommendations of the weekly meeting will be forwarded to the quarterly QA meeting for review of recommendations and further follow up as indicated.</p>	



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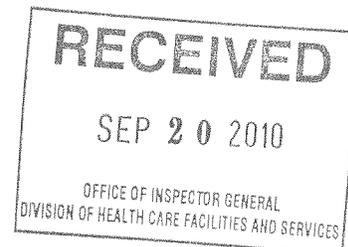
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F 431	<p>Continued From page 19</p> <p>consists of a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. The Pharmacist reviews the medication regimen of each resident at least monthly and the findings and recommendation are reported to the Director of Nursing and when appropriate, to the Administration and Medical Director.</p> <p>Observation of East and West medication carts on 08/25/10 at 4:20pm revealed three (3) bottles of medication that had been discontinued by the physician and was not removed from the medication cart. The medications included Miralax discontinued on 07/02/10 and Guaifenesin DM Syrup on 06/14/10.</p> <p>Observation of East and West medication carts on 08/25/10 at 4:20pm revealed six (6) liquid medications that had been opened and not labeled with the open date; Potassium Chloride liquid, Reglan liquid, Carafate slurry, Robitussin DM liquid, Phenytoin Suspension, and Chloraseptic Spray.</p> <p>Record review on 08/25/10 revealed the physician's order to discontinue the Miralax was written on 07/02/10 and the physician's order to discontinue the Guaifenesin DM syrup was written on 06/14/10.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 08/25/10 at 4:20pm revealed the practice was to date all medication when they are opened for first time use. LPN #4 reported he/she did not know why these six (6) liquid bottles of medications were not labeled when opened. The LPN reported the medications are supposed to be</p>	F 431			



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F 431	Continued From page 20 removed from the medication carts when the doctor writes the order to discontinue the medications. Interview with Director of Nursing (DON) on 08/25/10 at 4:10pm revealed the practice is to date all medications when they are opened for first time use. The DON reported the discontinued medication should be put in the locked medication room and then returned to the pharmacy or waste if the pharmacy will not take the medications back. She reported all narcotics are accounted for and returned or wasted as per pharmacy/nursing policy. The DON reported she did not know why these six (6) liquid bottles of medications were not labeled with the open date when they were first opened. She reported the medications are removed from the medication carts when the doctor writes the order to discontinue the medications.	F 431			



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K 000	INITIAL COMMENTS A standard Life Safety Code survey was conducted on August 25, 2010. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70(a) relating to NFPA 101 Life Safety Code 2000 Edition, with no regulatory violations identified on the date of the survey.	K 000			

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

[Handwritten Signature]

TITLE

Administrator

(X8) DATE

9/17/10

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

