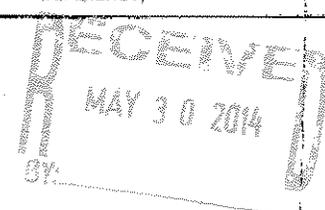


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/24/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00021593 and KY00021564 was initiated on 04/22/14 and concluded on 04/24/14. KY00021593 and KY00021564 were substantiated. Deficiencies were cited with the highest Scope and Severity of an "F".	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure residents received services with reasonable accommodation of individual needs and preferences for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure Resident #1's call bell was within reach and accessible to the resident. The findings include: Review of the facility's policy titled, "Call Light System" effective December 2010, revealed each resident should be provided with a functional call light system within his/her reach. Continued review revealed when a resident was in his/her room, staff should ensure the call light was	F 246	 Immediate Corrective Action For Residents Found To Be Affected <ul style="list-style-type: none"> Resident #1's call light was placed back within reach on 04/24/14 as care planned & staff were re-educated by the Director of Nursing (DON) on 04/24/14 on this resident's need for the call light to be within reach whenever resident is present in room. Resident was assessed to ensure no negative outcome relative to this alleged deficient practice. Identification of Other Residents With The Potential to be Affected <ul style="list-style-type: none"> An audit of 100% of the resident population on the Long Term Care Unit was completed on 05/13/14 by the Administrator reviewing call light placement for all residents to ensure 100% compliance. All residents on the Transitional Care Unit are alert and 	

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

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

05/29/2014

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

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F 246	<p>Continued From page 1</p> <p>always within easy reach of the resident, whether the resident was in or out of bed, or able to utilize the call light.</p> <p>Observation on 04/22/14 at 3:20 PM, revealed Resident #1 sitting up in a wheel chair, and had spilled a liquid on the floor. Continued observation revealed Resident #1's call light was out of the resident's reach. Further observation on 04/22/14 at 4:20 PM, revealed Resident #1's call light had been placed in reach of resident.</p> <p>Observation of Resident #1 on 04/24/14 at 8:15 AM, revealed Resident #1's call light lying on the floor and not accessible to the resident. In addition, observation at 1:45 PM revealed the call light remained on the floor and not accessible to Resident #1.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, who was responsible for Resident #1's care on 04/24/14 at 1:45 PM, revealed she had been in Resident #1's room several times to provide care; however had not noticed the resident's call light was lying on the floor.</p> <p>Interview with Unit Manager (UM) #3 on 04/24/14 at 2:05 PM, revealed her expectation was for staff to ensure call lights were accessible to residents as per the policy and if it fell, staff should retrieve it and place it in reach of the resident.</p> <p>Interview with the Director of Nursing on 04/24/14 at 5:35 PM, revealed her expectation was for the call light to be within reach of the resident while he/she was in his/her resident room as per the facility's policy.</p> <p>Interview with the Administrator on 04/24/14 at</p>	F 246	<p>oriented with no concerns expressed. No other resident(s) were identified as being effected.</p> <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> • in-servicing for all facility staff provided by the Staff Development Coordinator (SDC), DON, Minimum Data Set Coordinator (MDS), Unit Coordinator (UC), Weekend Nurse Supervisor (WNS), &/or Social Services Director (SSD) from April 24th - June 6th, 2014 regarding the importance of having call lights within reach when resident is in their room. • SDC, DON, UC, MDSC, WNS will re-educate Nursing Staff April 24th- June 6th, 2014 regarding their responsibility for ensuring call lights are within reach of each resident during routine rounds. Any findings of non-compliance will be immediately corrected either by the Charge Nurse (CN) or State Registry Nursing Assistance (SRNA). The staff responsible for the non-

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F 246	Continued From page 2 6:25 PM, revealed her expectation was for staff to check a resident at a minimum every two (2) hours and more frequently as needed to include ensuring the call light was in reach. She stated Resident #1 had a history of throwing his/her call light; however, she indicated staff should ensure the call light was within reach of the resident prior to exiting the room.	F 246	compliance will be re-educated &/or disciplinary action by either the WNS or DON.		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to ensure residents were assessed using the Annual Comprehensive Minimum Data Set (MDS) Assessment not less than every twelve (12) months for one (1) of nine (9) sampled residents (Residents #6). Review of Resident #6's Annual MDS Assessment revealed an Assessment Reference Date (date indicative of when the MDS was due to be completed) of 01/16/14; however the MDS Assessment was not signed as completed by the Registered Nurse (RN) MDS Coordinator until 04/23/14. The findings include: Review of the facility's policy titled, "Mandatory	F 275	Monitoring Changes To Assure Continuing Compliance • Audit of Call Light placement on 10% of residents will be done by Staff Development Coordinator (SDC), SSD/Quality of Life Director (QoLD), Medical Records Manager (MRM), Plant Operations Director (POD) &/or WNS daily x 3 weeks, then weekly x 8 weeks. Results of audits will be submitted to the Quality Assurance Committee for review & guidance until 100% compliance is achieved. Date of Completion: 06-06-14 F 275 Immediate Corrective Action For Residents Found To Be Affected • Resident #6 had MDS completed by MDSC on 04/28/14. Identification of Other Residents With The Potential to be Affected		

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F 275	<p>Continued From page 3</p> <p>Standards of Practice", revised 09/16/13, revealed the MDS Coordinator was complete residents assessments expected to "follow all Regulatory Guidelines", as determined by the RAI/MDS Manual, when completing resident assessments including, but was not limited to, timely scheduling of all resident assessments.</p> <p>Review of the RAI User Manual Version 3.0, revised May 2011, revealed the Assessment Reference Date (ARD) referred to the "last day of the period of time the MDS Assessment" covered for that "particular assessment for that particular resident". Continued review revealed the RN MDS Coordinator was to sign the Assessment and date it no later than the ARD date plus fourteen (14) calendar days after the ADR date. Review of the Manual revealed the Annual (Comprehensive) Assessment was to be completed at least every three hundred and sixty-six (366) days.</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 06/13/05, with diagnoses which included Dementia with Behaviors, Psychosis, Osteoporosis, Hypothyroidism and Esophageal Reflux.</p> <p>Review of Resident #6's MDS Assessments revealed an Annual MDS Assessment with an ARD of 01/16/14. However, continued review of this Assessment revealed it had not been signed and dated as completed by the RN MDS Coordinator until 04/23/14, ninety-seven (97) days after the ARD.</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #6's Annual MDS Assessment was delinquent and should have</p>	F 275	<ul style="list-style-type: none"> A review by MDSC & corporate Clinical Reimbursement Specialist Consultant (CRSC) will be completed to identify who & how many annual assessments are identified as being out of compliance. Any MDS identified as being out of compliance will be completed by MDSC by 06/06/14. <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> MDSC received in-servicing on "RAI Guidelines for the Completion & Transmission of OBRA & PPS Assessments" on 04/23/14 by corporate CRSC. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> MDSC will report in morning Stand Up meeting to Administrator the MDS Schedule for the day. Administrator will follow-up daily for completion of that days scheduled MDS's. Findings to be reported at Quality Assurance Committee meeting for any recommendations. 	
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F 275 Continued From page 4
been completed in a timely manner. The MDS Coordinator revealed the MDS was late due to her department being behind in completing residents' MDS Assessments.

Interview with the Director of Nursing (DON) on 04/24/14 at 5:50 PM, revealed she knew the MDS Department was behind on completing residents' MDS Assessments. According to the DON, the facility's Corporate Office had been contacted by the Administrator and had helped with the MDS Assessments. The DON revealed the MDS Department remained behind in completing residents' MDS Assessments. She indicated she expected residents' MDS Assessments to be completed on time however.

Interview, on 04/24/14 at 6:25 PM, with the Administrator revealed she knew the MDS Department was behind on completing residents' MDS Assessments. The Administrator stated she had notified the facility's Corporate Office of this and Corporate staff assisted. She indicated however, she knew this continued to be a problem. According to the Administrator, all the residents' MDS Assessments should have been completed on time.

F 275
• Corporate CRSC will monitor assessments weekly x 12 weeks to assure continued compliance. Report of monitoring to be reported to the Quality Assurance Committee for any recommendations.

Date of Completion: 06-06-14

F 276 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

This REQUIREMENT is not met as evidenced by:

F 276 F 276
Immediate Corrective Action For Residents Found To Be Affected

• Resident #1 had MDS assessment completed 05/01/14, resident #2 had MDS assessment completed 04/18/14, resident #3 had MDS assessment completed, resident #7

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F 276	<p>Continued From page 6</p> <p>Based on interview, record review, review of the facility's policy and the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to ensure residents were assessed using the Quarterly review instrument not less frequently than every three (3) months for six (6) of nine (9) sampled residents (Residents #1, #2, #3, #7, #8 and #9). Review of the residents' Minimum Data Set (MDS) Assessments revealed the Quarterly MDS had not been completed every three (3) months as specified.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Mandatory Standards of Practice", revised 09/16/13, revealed the MDS Coordinator was expected to "follow all Regulatory Guidelines", as determined by the RAI/MDS Manual, when completing resident assessments including, but was not limited to, timely scheduling of resident assessments.</p> <p>Review of the RAI User Manual Version 3.0, revised May 2011, revealed the Assessment Reference Date (ARD) referred to the "last day of the period of time the MDS Assessment" covered for that "particular assessment for that particular resident". Review of the Manual revealed the assessment scheduling moved through a cycle of three (3) Quarterly Assessments followed by an Annual (Comprehensive) Assessment after completion of the Admission (Comprehensive) Assessment. Quarterly Assessments were to be completed at least every ninety-two (92) days from the last assessment of any type.</p> <p>1. Review of Resident #1's medical record</p>	F 276	<p>had MDS assessment completed 04/24/14, resident #8 had MDS assessment completed 04/23/14, & resident #9 had MDS assessment completed on 04/10/14 by MDS staff on & submitted on 04/30/14.</p> <p>Identification of Other Residents With The Potential to be Affected</p> <ul style="list-style-type: none"> A review of all resident assessments will be performed by MDSC & CRSC to identify who & how many Quarterly MDS assessments are out of compliance with completion. All Quarterly MDS assessments identified as out of compliance will be completed by 06/06/14. <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> MDSC received in-servicing on "RAI Guidelines for the Completion & Transmission of OBRA & PPS Assessments" on 04/23/14 by corporate CRSC. 		

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F 276	<p>Continued From page 6</p> <p>revealed the facility admitted the resident on 09/05/12, with diagnoses which included Respiratory Failure, History of Flu, History of Pneumonia and Congestive Heart Failure (CHF).</p> <p>Review of Resident #1's MDS Assessments revealed a Quarterly MDS Assessment with an ARD of 11/22/13. However, under Section Z0500 the Registered Nurse (RN) Assessment Coordinator "verifying assessment completion" revealed the assessment was not signed as completed until 12/12/13, indicating it was twenty (20) days past the ARD. Further review revealed a Quarterly MDS Assessment with an ARD of 02/21/14 with no documented evidence the RN Assessment Coordinator had signed the assessment as completed.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 2:30 PM, revealed Resident #1's current MDS Assessment was due February 2014; however was late being completed due to the facility's whole MDS process was behind.</p> <p>2. Review Resident #2's medical record revealed the facility admitted the resident on 09/27/07, with diagnoses which included Chronic Constipation, Insomnia, Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Chronic Venous Deficiency with Chronic Lower Extremity Edema, Obesity and Hyperlipidemia.</p> <p>Review of Resident #2's MDS Assessments revealed the last Quarterly Assessment with an ARD of 01/08/14, was not signed by the RN MDS Coordinator as completed until 04/18/14, over three (3) months after the ARD.</p> <p>Interview with the MDS Coordinator on 04/23/14</p>	F 276	<p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> • MDSC will report in morning Stand Up meeting to Administrator the MDS schedule for the day. Administrator will follow-up daily for completion of that days scheduled MDS's. Findings to be reported at Quality Assurance Committee meeting for any recommendations. • Corporate CRSC will monitor assessments weekly x 12 weeks to assure continued compliance. Report of monitoring to be reported to the Quality Assurance Committee for any recommendations by the Administrator. 		
			Date of Completion:	06-06-14	

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F 276	<p>Continued From page 7</p> <p>at 1:30 PM, revealed her department was behind on completing MDS Assessments and Resident #2's Quarterly Assessment was completed three (3) months late. The MDS Coordinator stated the MDS department used the information from Resident #2's medical record for the seven (7) days prior to the ARD to complete the assessment on 04/18/14. Continued interview with the MDS Coordinator revealed the Quarterly Assessment should have been completed by 01/15/14. The MDS Coordinator stated the next Quarterly Assessment was due in April but had not been completed yet.</p> <p>3. Review of Resident #3's medical record revealed the facility originally admitted the resident on 08/22/03, and re-admitted the resident on 12/24/09, with diagnoses which included Dementia, Parkinson's Disease, Anemia, Acute Renal Failure and Status Post Left Hip Hemiarthroplasty.</p> <p>Review of Resident #3's MDS Assessments revealed the last Quarterly Assessment had an ARD of 12/19/13. However, was not signed by the RN MDS Coordinator as completed until 02/10/14, fifty-three (53) days after the ARD. Further review revealed no documented evidence an MDS Assessment had been completed three (3) months after the ARD of 12/19/13.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 2:32 PM, revealed the MDS department used the information from Resident #3's medical record for the seven (7) days prior to the ARD of 12/19/13, to complete the assessment on 02/10/14. The MDS Coordinator stated the Quarterly Assessment should have been completed and signed in December 2013. The</p>	F 276			

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F 276	<p>Continued From page 8</p> <p>MDS Coordinator indicated Resident #3 was due for another Quarterly Assessment in March 2014, but this assessment had not been completed as of 04/23/14.</p> <p>4. Review of Resident #7's medical record revealed the facility admitted the resident on 06/08/12, with diagnoses which included Hypertension, Multiple Sclerosis, Depression and Muscle Weakness.</p> <p>Review of Resident #7's MDS Assessments revealed a Quarterly Assessment with an ARD of 01/13/14, which was not signed by the RN MDS Coordinator as completed until 04/18/14, over three (3) months after the ARD.</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #7's Quarterly Assessment was completed late due to her department being behind in completion of residents' MDS Assessments. The MDS Coordinator stated the information for the Quarterly Assessment was from looking back in Resident #7's medical record for the seven (7) days prior to the ARD of 01/13/14.</p> <p>5. Review of Resident #8's medical record revealed the facility admitted the resident on 04/10/12, and re-admitted him/her on 09/05/12, with diagnoses which included Anemia, Heart Failure, Hypertension and Non-Alzheimer's Dementia.</p> <p>Review of Resident #8's MDS Assessments revealed a Quarterly Assessment with an ARD of 01/13/14, which was not signed by the RN MDS Coordinator as completed until 04/23/14, over three (3) months after the ARD.</p>	F 276		

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F 276	<p>Continued From page 9</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #8's Quarterly Assessment was not completed on time due to the department being behind in completion of residents' MDS Assessments.</p> <p>6. Review of Resident #9's medical record revealed the facility admitted the resident on 11/08/13, with diagnoses which included Hypertension, Hyperlipidemia, History of Cardiovascular Accident (CVA), and Cerebrovascular Disease.</p> <p>Review of Resident #9's MDS Assessments revealed a Quarterly Assessment with an ARD of 02/12/14, which was not signed by the RN MDS Coordinator as completed until 04/10/14, fifty-seven (57) days after the ARD.</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #9's Quarterly Assessment was completed seven (7) weeks late due to her department being behind in residents' MDS completion. The MDS Coordinator indicated information from Resident #9's medical record for the seven (7) days prior to the ARD of 02/12/14 had been used for completing the Quarterly MDS Assessment on 04/10/14.</p> <p>Interview with the Director of Nursing (DON) on 04/24/14 at 5:50 PM, revealed she was aware the MDS Department was behind on completing residents' Quarterly Assessments. The DON stated the Administrator had notified the facility's Corporate Office regarding this matter and indicated Corporate staff did come and help. She stated however, the MDS Department still remained behind on MDS Assessment</p>	F 276		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/24/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	
(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 276	Continued From page 10 completion and she was aware of this. The DON stated her expectation was for residents' MDS Assessments to be completed on time. Interview with the Administrator on 04/24/14 at 8:25 PM, revealed she was aware the MDS Department was behind on completing the Quarterly MDS Assessments. She indicated she had contacted the facility's Corporate Office regarding the MDS Department being behind on MDS completion. According to the Administrator, Corporate staff came to assist; however, the MDS Department was still behind in completing residents' MDS Assessments and she was aware of this. The Administrator stated residents' MDS Assessments should have been completed on time.	F 276		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Immediate Corrective Action For Residents Found To Be Affected • Resident #1, #2, #3, #5, #6, & #9's Comprehensive Care Plans were revised by the MDSC on 04/25/14 to reflect the resident's current status. Identification of Other Residents With The Potential to be Affected • Signature Clinical Consultant completed audit of 100% of residents' Complete Care Plans on 06/06/14 to ensure each residents' Complete Care Plan is current & reflects resident's current status.	

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F 280: Continued From page 11

This REQUIREMENT is not met as evidenced by:
Based on record review, interview and review of the facility's policy it was determined the facility failed to ensure the Comprehensive Care Plan was reviewed and revised by a team of qualified persons after completion of each Minimum Data Set (MDS) Assessment for six (6) of nine (9) sampled residents (Resident #1, #2, #3, #5, #6, and #9). Review of the Comprehensive Care Plans for these residents revealed the facility failed to update and/or revise the care plans after mandatory MDS Assessments.

The findings include:

Review of the facility's policy titled, "Care Plan", effective date December 2010, revealed the Interdisciplinary Care Plan should be reviewed, revised and updated Quarterly and more frequently if warranted by a change in the resident's condition.

Review of the facility's policy titled, "Skin Management and Prevention", revised August 2013, revealed care plans needed to be revised and/or updated at the time of new skin alterations.

1. Record review revealed the facility admitted Resident #1 on 09/05/12, with diagnoses which included Respiratory Failure, a History of Flu and Pneumonia and Congestive Heart Failure.

Review of the facility's MDS Assessments for

F 280: Measures Taken To Assure There Will Not Be a Recurrence

- In-servicing was provided by the CRSC on 04/23/14 for the MDS staff regarding the importance of the Comprehensive Care Plan, that it be kept current & reflect the residents current status.
- SDC, DON, MDSC will In-service the licensed nursing staff by 06/06/14 regarding the responsibility of the licensed staff to monitor Comprehensive Care Plans to ensure they are current & reflect the current status of each respective resident.
- On 05/22/14 SCC & SSD in-serviced MDSC, MDS staff, CDM, & UC on Care Plans & the Care Plan Meeting to ensure Care Plan team members have understanding of the Care Plan meeting, the responsibility of the team members, what should occur prior to the meeting, what should occur/be covered during the meeting; differences between the Interim Care Plan & the Complete Care Plan; resident & family

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F 280	<p>Continued From page 12</p> <p>Resident #1, revealed a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/22/13 which was not signed by the Registered Nurse (RN) MDS Coordinator as completed until 12/12/13. Continued review Resident #1's MDS Assessments revealed a Quarterly MDS assessment with an ARD of 02/21/14 which had not been signed as completed by the RN MDS Coordinator.</p> <p>Review of Resident #1's Comprehensive Care Plan revealed no documented evidence it had been revised or updated Quarterly or more frequently. Further review of the Comprehensive Care Plan goals and interventions revealed no documented evidence they had been reviewed and updated since 11/22/13.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 2:30 PM, and on 04/24/14 at 4:37 PM and 4:45 PM, revealed Resident #1's current MDS Assessment and Comprehensive Care Plan review had been due in February 2014; however these were late due to the facility's whole MDS process being behind.</p> <p>2. Record review revealed the facility admitted Resident #2 on 09/27/07, with diagnoses which included Coronary Artery Disease, Diabetes and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of Resident #2's MDS Assessments revealed the last Quarterly Assessment with an ARD of 01/08/14, however, was not signed as completed by the RN MDS Coordinator until 04/18/14, over three (3) months after the ARD.</p> <p>Review of Resident #2's Comprehensive Care Plan revealed the care plan was not revised or</p>	F 280	<p>involvement with the Care Plan being established & keeping it current; resident & family role as part of the Care Plan team.</p> <ul style="list-style-type: none"> DON, SDC, & SCC beginning 05/27/14 will complete weekly audits for 4 weeks on 10% of random resident population to ensure Comprehensive Care Plans are current & reflect resident's current status with annual & quarterly dates up to date. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> Audit results will be submitted to the Quality Assurance Committee by the DON for review & recommendations until the committee has determined substantial compliance is achieved. <p>Date of Completion: 06/06/2014</p>		

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F 280	Continued From page 13 updated Quarterly as per the policy or more frequently as needed; and was not revised if warranted by a change in the resident's condition. Continued review of the care plan revealed Resident #2's goals had not been revised or updated since 08/15/13. Review of the interventions revealed the resident's interventions not updated or revised since 05/15/13, except one (1) problem area with interventions updated on 10/10/13. Further review of the care plan revealed Resident #2 had a problem for at risk for stasis ulcers or open lesions, caused by poor circulation. Record review revealed Resident #2 had open wounds on his/her lower extremities documented in October 2013, November 2013, and February 2014. However, additional review of the care plan revealed no documented evidence it had been updated or revised since 05/15/13. 3. Record review revealed the facility admitted Resident #3 on 08/22/03, and re-admitted the resident on 12/24/09, with diagnoses which included Dementia, Parkinson's Disease, Anemia, Acute Renal Failure and Status Post Left Hip Hemiarthroplasty (a surgical procedure for repair of an injured or diseased hip joint involving replacing the head of the femur with a prosthesis) Review of Resident #3's MDS Assessments revealed the last Quarterly Assessment had an ARD of 12/19/13; however, was not signed by the RN MDS Coordinator as completed until 02/10/14. Review of Resident #3's Comprehensive Care Plan revealed no documented evidence the care plan had been revised or updated after 02/10/14. Review of the care plan revealed problem dates of 12/31/13.	F 280			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324
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F 313 Continued From page 27

providing proper treatment to maintain vision in regards to making necessary appointments for one (1) of nine (9) sampled residents (Resident #2).

The facility failed to ensure Resident #2 had a follow up appointment scheduled as recommended by the Physician after his/her cataract surgery.

The findings include:

Record review revealed the facility admitted Resident #2 on 09/27/07, with diagnoses which included Diabetes and Chronic Venous Deficiency with Chronic Lower Extremity Edema. Continued record review revealed Resident #2 had cataract surgery on 06/25/13, and the Physician who had performed the surgery recommended the resident return one (1) week post procedure for a vision check. Further record review revealed no documented evidence Resident #2 had been scheduled for a follow up appointment for a vision check as recommended by the Physician. Additionally, record review revealed no documented evidence Resident #2 had returned to the Physician for a vision check since the cataract surgery was completed.

Interview by telephone on 04/24/14 at 1:43 PM, with the Physician's Receptionist, where Resident #2's cataract surgery was performed, revealed the resident had not returned for a follow up visit as recommended after the cataract surgery on 06/25/13.

Interview with the Unit Manager on 04/24/14 at 5:25 PM, revealed a follow up appointment should have been made by the receiving nurse

F 313

admission Physician orders to include all appointments was started 05/23/14 & completed on 05/27/14 by the DON, UC & Medical Records Coordinator (MRC) for the prior 2 months. No residents were identified to be affected by this alleged deficient practice.

Measures Taken To Assure There Will Not Be a Recurrence

- An in-service for all Nursing Staff was initiated on 04/28/14 by the DON regarding follow up on all resident appointments/following physician orders & will conclude on 06/06/14 by the SDC &/or the SCC related to following Physician orders. This in-service will be done on-going by the SDC &/or DON for new hires during their orientation period.
- All Physician orders will be reviewed daily in the morning Clinical meetings with the DON, UC, SDC & IDT to ensure all Physician orders are implemented. DON will place any orders needing follow up on an

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F 313	Continued From page 28 for Resident #2 upon return from the cataract surgery. The Unit Manager stated the follow up appointment should have been written on the appointment calendar. Further interview revealed the Unit Manager was unsure how the follow up appointment was missed by the receiving nurse. The Unit Manager indicated Resident #2 should have had a follow up appointment as recommended by the Physician. Interview with the Director of Nursing (DON) on 04/24/14 at 5:35 PM, revealed it was her expectation for the nurse receiving a resident after surgery to ensure a follow up appointment was made if recommended and not already scheduled. The DON stated the receiving nurse should write the appointment on the appointment calendar. According to the DON, she was not sure how the recommendation for a follow up appointment was missed by the receiving nurse. She indicated Resident #2 should have had a follow up appointment after his/her cataract surgery as recommended by the Physician.	F 313	Action Item List to ensure follow up appointments are made. • The WNS will review the weekend orders to ensure Physician orders are implemented on weekends. Weekend Physician orders will be reviewed again on Mondays to ensure any diagnostics &/or appointments are made. Monitoring Changes To Assure Continuing Compliance • The DON, UC &/or SDC will audit Physician orders daily x one month, then weekly x 8 weeks to ensure compliance with Physician orders. • The WNS will audit Physician orders on Saturday & Sunday to ensure compliance with Physician orders. The weekend audits will be given to/left for the DON/designee to review. • Audit results of Physician orders will be submitted by DON to the Quality Assurance Committee at least quarterly for review &		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371			

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F 371	Continued From page 29 by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by observation during a meal service of dietary staff serving food without utilizing utensils and not washing their hands between tasks. The findings include: Review of the facility's Dietary policy titled, "Sanitation and Hand Washing", undated, revealed tongs or serving utensils should be used with all ready to eat food; and bare hand contact was not permitted. Further review revealed staff should wash their hands when arriving or returning to the kitchen. Observation during the lunch meal service on 04/22/14 at 12:06 PM, revealed a dietary staff person while gloved, touching ladles, a wooden serving area and plates; then going to the paper towel dispenser obtaining a paper towel and walked back to the serving area, where he/she wiped the bar, went to the trash bin and disposed of the soiled towel all without removing the soiled gloves and washing his/her hands. Continued observation revealed this staff person returned to the serving area and continued to serve residents' food without washing his/her hands and donning clean gloves. Additionally, observation of this same staff person serving rolls/bread item revealed he/she did not utilize tongs or any other utensil. Interview with the Dietary Manager on 4/24/14 at 1:00 PM, revealed dietary staff should wash their hands and don clean gloves between	F 371	(F313 cont) recommendations to ensure 100% compliance is achieved. Date of Completion: 06/06/14 F 371 Immediate Corrective Action For Residents Found To Be Affected • No specific resident(s) were identified. Further, no resident was identified in Infection Control Tracking & Trending report that would have been affected by the alleged practice(s). However, Certified Dietary Manager (CDM) immediately corrected all items noted within the form 2567. CDM & Corporate Chef did in-service the in-house dietary staff, on that shift, on April 22, 2014 relative to proper procedures related to the alleged practice(s). Identification of Other Residents With The Potential to be Affected • CDM performed a sanitation inspection on April 22, 2014 to		

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F 371	Continued From page 30 performance of tasks. The Dietary Manager stated staff should utilize tongs to serve food to decrease cross contamination. Continued interview with the Dietary Manager revealed the facility had implemented educational training to include hand washing and sanitation which was completed with dietary staff on 04/22/14. Interview with the Regional Dietary Director on 04/22/14 at 12:39 PM, revealed the facility had requested his assistance as it had identified dietary as an area which needed to improve services. The Regional Dietary Director stated the facility's dietary department had a lot of new staff with education ongoing. He stated the facility had identified areas of improvement and were in the process of implementing changes. According to the Regional Dietary Director, staff should wash their hands and don gloves prior to serving food and between tasks. He stated dietary staff should use utensils to serve food and not their hands in order to decrease cross contamination and for infection control.	F 371	assure no additional issues were identified – none were noted. • Infection control mapping will be updated daily, Monday – Friday, from 05/01/14 thru 05/30/14 by the DON to identify any possible spikes in infections throughout the facility. None have been noted as of 05/27/14. Measures Taken To Assure There Will Not be a Recurrence • CDM in-serviced dietary staff on April 22, 2014 relative to food procurement, preparation & serving under sanitary conditions to include proper use of utensils to include tongs & proper hand washing with glove changes specifically as provided within Facility Policies & the Kentucky Food Code. • Registered Dietician (RD) in-serviced on May 28, 2014 remaining staff not working on April 22, 2014 regarding the proper procedures for sanitation, hand washing, use of tongs to serve food, & gloving.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441			

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F 441	Continued From page 31 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to Infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. This was evidenced by the following: observation during initial tour of residents' nasal cannulas lying unprotected on the floor in resident rooms; observation during a meal service of staff	F 441	(F 371 cont) • CDM to re- in-service dietary staff on June 3 - 5 2014 regarding proper procedures for sanitation, hand washing, use of tongs to serve food & gloving. • Direct observations/monitoring for proper food preparation & serving under sanitary conditions, proper hand washing & gloving will be done by CDM &/or RD 4 times a week x 12 weeks. Results of the weekly observations/monitoring will be reported by the CDM to the Administrator each week x 12 weeks. Monitoring Changes To Assure Continuing Compliance • Administrator, CDM, SSD, Plant Operations Director (POD)/Interim Environmental Services Director (ESD), will observe/monitor for proper food preparation & serving under sanitary conditions, proper hand washing & gloving weekly x 12 wks for compliance beginning May 27, 2014.		

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F 441	Continued From page 32 touching their glasses and/or clothing without utilizing proper hand hygiene; observation of staff buttering a resident's roll with their bare hands; and observation during a medication pass of poor hand hygiene. The findings include: 1. Review of the facility's policy titled, "Oxygen therapy, Respiratory Care/Nasal Cannula", effective date December 2010, revealed nasal cannulas were to be kept off of the floor when not in use. Observation on 04/22/14 at 10:30 AM of Unsampld Resident A's room during initial tour, revealed a nasal cannula lying on the floor by the resident's bed. An additional observation on 04/24/14 at 2:15 PM, of Unsampld Resident A's room revealed the nasal cannula once again lying on the floor. Interview with Registered Nurse (RN) #1 on 04/24/14 at 2:35 PM, revealed Unsampld Resident A's nasal cannula should not have been lying on the floor. RN #1 stated the nasal cannula should have been stored in a storage bag when not in use. The RN indicated this was for infection control reasons. Interview with the Director of Nursing (DON) on 04/24/14 at 5:35 PM, and the Administrator at 6:25 PM, revealed their expectations were for staff to ensure nasal cannulas and oxygen tubing were kept off of the floor and stored in a bag when not in use for infection control purposes. 2. Review of the facility's policy titled, "Sanitation and Hand Washing", undated, revealed bare	F 441	(F371 cont) • Results of weekly direct observations/monitoring for proper food preparation & serving under sanitary conditions to include proper hand washing with glove changes, as well as, proper use of utensils including tongs was added to the monthly Dietary Quality Assurance Report beginning with May 2014 for the June Quality Assurance Committee meeting. Results of the monthly Dietary Quality Assurance Report to be presented by Administrator at least quarterly for review & recommendations to ensure 100% compliance is achieved. Date of Completion: 06/06/14 F 441 Immediate Corrective Action For Residents Found To Be Affected • Unsampld Resident A's oxygen tubing & nasal cannula were replaced on April 22, 2014 by the licensed nurse. Resident was also	

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F 441	Continued From page 33 hand contact was not permitted. Continued review revealed longs or serving utensils should be used with all ready to eat food. Observation during the lunch meal service on 04/22/14 at 12:20 PM, revealed Certified Nursing Assistant (CNA) #3 buttering a resident's roll and touching the roll with her bare hands. Continued observation revealed CNA #4 to re-adjust her glasses and continue to prepare resident's meal trays without sanitizing hands. Interview with the Dietary Manager, on 04/24/14 at 1:00 PM, and the Administrator on 04/24/14 at 6:40 PM, revealed staff should wash their hands prior to serving or preparing the meal tray and after adjusting glasses or clothing. Further interview revealed staff should not touch a resident's food with their bare hands. The Administrator indicated this was to decrease cross contamination and for infection control. 3. Review of the facility's policy titled, "Medication Administration-Administering Medications" dated December 2010, revealed staff should wash their hands before beginning medication pass and after any direct contact with residents. Observation on 04/24/14 at 8:53 AM, during a medication pass revealed RN #3 to administer part of a resident's medications. RN #3 was observed to then wash her hands, leave the resident's room, return to the medication cart at the nursing station, open several drawers in the medication cart and use the computer prior to returning to the resident's room. Observation revealed upon re-entering the resident's room RN #3 entered the bathroom and donned gloves without first washing her hands. Further	F 441	assessed by DON & UC to have no s/s of active infections. Identification of Other Residents With The Potential to be Affected • Infection Control mapping will be updated daily, Monday – Friday from 05/01/14 thru 05/30/14 by the DON to identify any possible spikes in infections throughout the facility. None have been noted as of 05/27/14. Measures Taken To Assure There Will Not Be a Recurrence • Education began on 04/29/14 by the SCC with facility stakeholders regarding hand washing, monitoring for prevention of infection & feeding residents to include infection control techniques. Education will be ongoing by the SDC until 100% of stakeholders have attended the in-service. • Infection Control mapping will be reviewed monthly by the DON & UC to identify any possible spikes in infections throughout the facility.	

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F 287	<p>Continued From page 22</p> <p>revealed the last Quarterly Assessment had an ARD of 12/19/13. However, continued review of this MDS revealed the RN MDS Coordinator had not signed the MDS as completed until 02/10/14, fifty-three (53) days after the ARD date of 12/19/13. Review of the MDS revealed no documented evidence this Assessment was encoded within seven (7) days or transmitted within fourteen (14) days as per the regulatory requirements. Further review of Resident #3's MDS Assessments revealed no documented evidence an Assessment had been completed within three (3) months, encoded and transmitted as per the regulatory requirements.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 2:32 PM, revealed the MDS department used the information from Resident #3's medical record for the seven (7) days prior to the ARD of 12/19/13, to complete the assessment on 02/10/14. The MDS Coordinator indicated the Quarterly Assessment should have been completed and signed in December 2013, and encoded and transmitted at that time. She stated Resident #3 was due for another Quarterly Assessment in March 2014, however, indicated this Assessment had not been performed, encoded and transmitted as of 04/23/14.</p> <p>4. Record review revealed Resident #5 was admitted by the facility on 12/06/13.</p> <p>Review of the facility's assessment for Resident #6, revealed a Discharge Assessment with return anticipated indicated which was dated 12/26/13, however, not signed by the RN MDS Coordinator as completed until 02/02/14.</p> <p>Interview with the MDS Coordinator, on 04/24/14</p>	F 287			

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F 287	<p>Continued From page 23</p> <p>at 2:32 PM, revealed the MDS should have been signed, encoded and transmitted prior to 02/02/14; however her department was behind with doing this.</p> <p>5. Review of Resident #7's medical record revealed the facility admitted the resident on 06/08/12.</p> <p>Review of Resident #7's MDS Assessments revealed a Quarterly Assessment with an ARD of 01/13/14, which the RN MDS Coordinator had not signed as completed until 04/18/14, over three (3) months after the ARD. Further review of the Quarterly Assessment revealed no documented evidence it was encoded and transmitted as per regulatory requirements.</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #7's Quarterly Assessment was completed late due to her department being behind in completion of residents' MDS Assessments. The MDS Coordinator indicated the Assessment had not been encoded and transmitted as it should have been.</p> <p>6. Review of Resident #8's medical record revealed the facility admitted the resident on 04/10/12, and re-admitted him/her on 09/05/12.</p> <p>Review of Resident #8's MDS Assessments revealed a Quarterly Assessment with an ARD of 01/13/14, which the RN MDS Coordinator had not signed as completed until 04/23/14, over three (3) months after the ARD. Further review of the Quarterly Assessment revealed no documented evidence it was encoded and transmitted as per regulatory requirements.</p>	F 287		

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F 287	Continued From page 24 Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #8's Quarterly Assessment was not completed on time due to the department being behind in completion of residents' MDS Assessments. The MDS Coordinator indicated therefore, it was not encoded and transmitted as it should have been. 7. Review of Resident #9's medical record revealed the facility admitted the resident on 11/08/13. Review of Resident #9's MDS Assessments revealed a Quarterly Assessment with an ARD of 02/12/14, which the RN MDS Coordinator had not signed as completed until 04/10/14, fifty-seven (57) days after the ARD. Further review of the Quarterly Assessment revealed no documented evidence it was encoded and transmitted as per regulatory requirements. Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #9's Quarterly Assessment was completed seven (7) weeks late due to her department being behind in residents' MDS completion. The MDS Coordinator indicated information from Resident #9's medical record for the seven (7) days prior to the ARD of 02/12/14 had been used for completing the Quarterly MDS Assessment on 04/10/14, encode it on 04/10/14 and transmit it after 04/10/14. 3. Review of Resident #6's medical record revealed the facility admitted the resident on 06/13/05. Review of Resident #6's MDS Assessments revealed an Annual Assessment with an ARD of	F 287		
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F 287	<p>Continued From page 25</p> <p>01/16/14. However, continued review of this Assessment revealed it had not been signed and dated as completed by the RN MDS Coordinator as of 04/23/14, ninety-seven (97) days after the ARD. Further review of the Quarterly Assessment revealed no documented evidence it was encoded and transmitted as per regulatory requirements.</p> <p>Continued review of the MDS Assessments revealed a Discharge Assessment with an ARD of 12/19/13, which had not been signed and dated as completed by the RN MDS Coordinator until 02/10/14. Additionally, review of the MDS Assessments revealed a Discharge Assessment with an ARD of 03/25/14, was not signed and dated by the MDS Coordinator indicating it had been completed. Further review of these Discharge Assessments revealed no documented evidence they were encoded and transmitted as per regulatory requirements.</p> <p>Interview with the MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #6's MDS Assessments were delinquent and should have been completed in a timely manner. The MDS Coordinator revealed the MDS Assessments were late due to her department being behind in completing residents' MDS Assessments. The MDS Coordinator indicated therefore, they were not encoded and transmitted as they should have been.</p> <p>Interview with DON on 04/24/14 at 5:50 PM revealed she was aware the MDS department was behind on completing the MDS Assessments. She stated the Administrator had notified the facility's Corporate Office regarding the MDS department being behind with the</p>	F 287			

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F 287	Continued From page 26 completion and Corporate staff had come and assisted her staff. The DON stated however, she was aware the MDS Department still remained behind in completing the MDS Assessments. The DON indicated she expected MDS Assessments to be completed on time, encoded, and transmitted on time as per the regulatory requirements. Interview with the Administrator on 04/24/14 at 6:25 PM, revealed when she had become aware the MDS department was behind on MDS completion she had notified the facility's Corporate Office who had sent staff to assist. The Administrator stated she was also aware the MDS Department continued to remain behind in completing residents' MDS Assessments. She indicated the MDS Assessments should have been completed on time, encoded, and transmitted as per the regulatory requirements.	F 287		
F 313 SS=0	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to assist residents by	F 313	F 313 Immediate Corrective Action For Residents Found To Be Affected • Resident #2 to be seen by Dr. Richardson July 8, 2014 at 9:15 am. This was the earliest date resident could be seen by the physician per his office. Identification of Other Residents With The Potential to be Affected • A chart audit of 100% of residents with supplemental/post-surgical/re-	

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F 287	<p>Continued From page 19</p> <p>the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to ensure residents' MDS Assessments were encoded within seven (7) days and transmitted within fourteen (14) days for eight (8) of nine (9) sampled residents (Resident's #1, #2, #3, #5, #6, #7, #8 and #9).</p> <p>The findings include:</p> <p>Review of the facility's "Mandatory Standards of Practice", revised 09/16/2013, revealed the expectation was for the MDS Coordinator to "follow all Regulatory Guidelines" when completing residents' MDS Assessments, as per the RAI/MDS Manual.</p> <p>Review of the RAI User Manual Version 3.0, revised May 2011, revealed the Assessment Reference Date (ARD) referred to the "last day of the period of time the MDS Assessment" covered for that "particular assessment for that particular resident". Review of the Manual revealed assessments were to be encoded within seven (7) days after completing a resident's assessment. Continued review of the Manual revealed residents' MDS Assessments were to be transmitted within fourteen (14) days of the Care Plan completion for Comprehensive Assessments; and all other MDS Assessments transmitted within fourteen (14) days of the completion date. Further review of the Manual revealed the MDS Assessment scheduling moved through a cycle of the Admission MDS Assessment followed by, three (3) Quarterly Assessments then an Annual (Comprehensive) Assessment. Quarterly Assessments were to be completed at least every ninety-two (92) days from the last assessment of any type and Annual</p>	F 287		
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F 287	<p>Continued From page 20</p> <p>Assessments completed within three hundred and sixty-six (366) days of the last Comprehensive Assessment.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident on 09/05/12.</p> <p>Review of Resident #1's MDS Assessments revealed a Quarterly MDS Assessment with an ARD of 11/22/13. However, review of the MDS revealed it was not signed by the RN MDS Coordinator as completed until 12/12/13, twenty (20) days past the ARD. Continued review of the MDS revealed there was no documented evidence the MDS Assessment was completed, encoded within seven (7) days and transmitted within fourteen (14) days as per the regulatory requirements. Additionally, review of Resident #1's MDS Assessments revealed a Quarterly MDS Assessment with an ARD of 02/21/14, with no documented evidence the RN MDS Coordinator had signed the assessment as completed, encoded it within seven (7) days and transmitted it within fourteen (14) days.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 2:30 PM, revealed Resident #1's current MDS Assessment was due February 2014; however was late being completed due to the facility's whole MDS process was behind. The MDS Coordinator indicated therefore, the MDS Assessment had not been encoded and transmitted as it was supposed to be.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/27/07.</p>	F 287			

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F 287	<p>Continued From page 21</p> <p>Review of Resident #2's MDS Assessments revealed the last Quarterly Assessment with an ARD of 01/08/14, and was not signed as completed until 04/18/14 by the RN MDS Coordinator, over three (3) months after the ARD. Further review revealed no documented evidence this Assessment was encoded within seven (7) days or transmitted within fourteen (14) days as per the regulatory requirements. Continued review of the MDS Assessments revealed no documented evidence of the next Quarterly MDS Assessment due to be completed in April.</p> <p>Interview with the MDS Coordinator on 04/23/14 at 1:30 PM, revealed Resident #2's Quarterly Assessment was completed three (3) months late as her department was behind on completing MDS Assessments. The MDS Coordinator stated when completing the MDS Assessment her department had used information obtained from Resident #2's medical record for the seven (7) day period prior to the ARD date of 01/08/14. The MDS Coordinator stated the Quarterly Assessment should have been completed by 01/15/14. However, she stated the Quarterly MDS Assessment had not been completed in the time frames it should have been and therefore had not been encoded until 04/18/14 and transmitted after 04/18/14. Further interview with the MDS Coordinator revealed Resident #2's next Quarterly Assessment due in April, but had not been completed, encoded and transmitted yet.</p> <p>3. Review of Resident #3's medical record revealed the facility originally admitted the resident on 08/22/03, and re-admitted the resident on 12/24/09.</p> <p>Review of Resident #3's MDS Assessments</p>	F 287		

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F 441	Continued From page 34 observation revealed the RN then proceeded to administer the rest of the resident's medications to him/her. Interview with RN #3 on 04/24/14 at 9:09 AM, revealed she should have washed her hands prior to donning the clean gloves when she administered the rest of the resident's medications. She indicated this was to decrease cross contamination. Interview with the DON on 04/24/17 at 5:47 PM, revealed staff should wash their hands upon entering a resident's room and prior to administering medications due to infection control and cross contamination.	F 441	Monitoring Changes To Assure Continuing Compliance <ul style="list-style-type: none"> • Infection Control audits will begin on 05/27/14 & will be completed by DON, UC, CDM, Chaplain, WNS, POD, &/or other designated staff on a daily basis to validate proper infection control technique is utilized during meal times. • Beginning the week of 05/26/14, the SDC will conduct an audit of 10% of Medication Administrations on each unit weekly x 4 weeks, then monthly x 3 months & then as directed by the Quality Assurance Committee. • These audits will continue for a three month period or until 100% compliance has been determined by the Quality Assurance Committee. Members of the Quality Assurance Committee include, but are not limited to, the Administrator, DON, SDC, Medical Director, SSD, CDM, Registered Dietitian (RD), QoLD, Business Office Manager (BOM), POD, ESD, & RPD. The results of 	

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F 441		F 441	<p>these audits will be brought to the Quality Assurance Committee monthly for the next three (3) months & then monthly for three months or until substantial compliance has been determined.</p> <p>Date of Completion: 06-06-13</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 280	Continued From page 14 and goal dates of 03/31/14. 4. Record review revealed the facility admitted Resident #5 on 12/06/13, with diagnoses which included Diabetes, Hypertension, Hyperlipidemia, Atrial Fibrillation and Cerebral Vascular Disease. Review of Resident #5's Comprehensive Care Plan revealed a care plan for at risk for falls and/or fall related injury due to muscle weakness and decreased mobility. Review of this care plan revealed no documented evidence it had been updated or revised from 12//13/13, until late entries were documented on 04/24/14. Review of the late entries made on 04/24/14 revealed the following: an alarm pad changed and new one applied on 12/26/13; Physical Therapy (PT) was consulted for evaluation of transfers on 03/05/14; and the resident was placed on close monitoring on 03/21/14. Interview with the MDS Coordinator, on 04/24/14 at 2:32 PM, revealed Resident #5's Comprehensive Care Plan was not reviewed and updated or revised as per the facility's policy. She indicated the late entries were made to reflect changes of the resident's condition. 5. Record review revealed the facility admitted Resident #8 on 06/13/05, with diagnoses which included Dementia with Behaviors, Psychosis, Osteoporosis, Hypothyroidism and Esophageal Reflux. Review of Resident #8's MDS Assessments revealed an Annual Assessment with an ARD of 01/18/14, however it had not been documented as completed by the MDS Coordinator.	F 280			

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F 280	Continued From page 15 Review of Resident #6's Comprehensive Care Plan revealed a care plan for "routine care needs" related to the resident's sleep preference to have a review date of 12/16/13, and the goal dates as 12/16/13 and 04/24/14. Continued review of the care plans revealed the care plans related to communication, potential for complications related to Hypertension/Hypotension, and self care deficit had review dates of 10/08/13, and goal dates of 04/16/14. Further review of the Comprehensive Care Plan revealed no documented evidence it had been reviewed and revised in January 2014, when the Annual MDS Assessment had been due to be completed. Interview with MDS Coordinator on 04/24/14 at 4:45 PM, revealed Resident #6's Comprehensive Care Plan was not reviewed and updated or revised as per the facility's policy due to the entire MDS process completion being behind. Further interview revealed Resident #6's Comprehensive Care Plan was due to be reviewed. 6. Record review revealed the facility admitted Resident #9 on 11/08/13, with diagnoses which included Hypertension (HTN), Hyperlipidemia, History of Cardiovascular Accident (CVA), Cerebrovascular Disease, General Muscle Weakness, Altered Mental Status, and Debility, Not Otherwise Specified (NOS). Review of Resident #9's Quarterly MDS revealed it was completed seven (7) weeks late on 04/10/14. Review of Resident #9's Comprehensive Care Plan revealed two (2) problems, one (1) problem for antibiotic therapy related to signs and symptoms of infection dated 12/01/13, and the other problem for alteration in	F 280		

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F 280	<p>Continued From page 18</p> <p>skin integrity related to a deep tissue injury dated 11/12/13. Further review of the Comprehensive Care Plan revealed twelve (12) other pages of problems the facility had identified for Resident #9 which were dated 04/24/14.</p> <p>Interview with MDS Coordinator, on 04/24/14 at 2:32 PM, at 4:37 PM, and at 4:45 PM, regarding Comprehensive Care Plans being reviewed and revised revealed she had just updated Resident #9's Comprehensive Care Plans on 04/24/14, prior to the care plans being given to the State Survey Agency Surveyors on that day. She indicated, although Resident #9 was admitted on 11/08/13, and the last quarterly MDS Assessment completed on 04/10/14, there had not been review and revision of the Comprehensive Care Plan completed to update the resident's problem areas. So, she stated, "I just started from today". The MDS Coordinator stated care plans should be updated Quarterly with the Assessments. However, she reported the facility's whole MDS process, including Comprehensive Care Plan review and revision was behind. She stated the care plans were updated when changes occurred in each resident's condition though; but this did not include the staff fully reviewing residents' Comprehensive Care Plans. She indicated the facility had a clinical meeting every weekday morning and care plans should have been updated and revised during that meeting as well. Further interview with the MDS Coordinator on 04/24/14 at 5:50 PM, revealed Comprehensive Care Plans should have been reviewed by the MDS Department quarterly, annually, and based on new orders when received.</p> <p>Interview with the DON on 04/24/14 at 5:50 PM revealed she was aware Comprehensive Care</p>	F 280	
(X5) COMPLETION DATE			

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F 280	Continued From page 17 Plan updates and revisions were being affected by the facility's MDS Assessments being performed late. She stated the facility had a clinical meeting Monday through Friday to discuss resident care and care plans were supposed to be updated and revised in those meetings, in addition to the update and revision which was supposed to occur with each MDS Assessment. According to the DON, she was not aware Comprehensive Care Plans were not being updated and revised as per the policy until 04/24/14, when it was brought to the facility's attention by the State Survey Agency Surveyors. The DON stated a one hundred (100) percent Comprehensive Care Plan audit was started on 04/24/14, at the time it was brought to the facility's attention, to attempt to get all residents' Comprehensive Care Plans reviewed, revised and updated. In addition, she stated her expectation was for residents' Comprehensive Care Plans to be revised and updated as per the facility's policy.	F 280		
F 287 SS=F	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 287	F 287 Immediate Corrective Action For Residents Found To Be Affected • Resident #1, #2, #3, #5, #6, #7, #8, & #9 had MDS encoding & transmission report reviewed & completed by MDS staff if not included on report, by 04/30/14.	

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F 287	Continued From page 18 (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's "Mandatory Standards of Practice" for Minimum Data Set (MDS) Coordinators and	F 287	Identification of Other Residents With The Potential to be Affected • A review of all resident MDS transmission reports will be performed by MDS staff with daily oversight by the CRSC with any identified assessments found to be out of compliance will be encoded & transmitted by 06/06/14. Measures Taken To Assure There Will Not Be a Recurrence • MDSC received in-servicing on "RAI Guidelines for the Completion & Transmission of OBRA & PPS Assessments" on 04/23/14 Monitoring Changes To Assure Continuing Compliance • Corporate CRSC will monitor assessments weekly x12 weeks to assure continued compliance. Report of monitoring to be reported to the Quality Assurance Committee for any recommendations. Date of Completion: 06-06-14	