

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

PRINTED: 07/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/02/2015
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023
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F 000 INITIAL COMMENTS

A Recertification Survey was conducted on  
06/30/15 through 07/02/15 with deficiencies cited  
at the highest Scope and Severity of an "E".

F 241 483.15(a) DIGNITY AND RESPECT OF  
SS=D INDIVIDUALITY

The facility must promote care for residents in a  
manner and in an environment that maintains or  
enhances each resident's dignity and respect in  
full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced  
by:

Based on observation, interview, record review  
and facility policy review, it was determined the  
facility failed to promote care in a manner and in  
an environment that maintains/enhances each  
resident's dignity and respect for one (1) of  
eleven (11) sampled residents (Resident #3)  
related to ensuring the privacy curtain was pulled  
shut during a skin assessment for Resident #3.

The findings include:

Review of the facility's policy titled, "Treatment:  
Considerate and Respectful", revised 09/01/13,  
revealed the facility was to promote care for  
patients in a manner and in an environment that  
maintained or enhanced each patient's dignity  
and respect in full recognition of his or her  
individuality. In addition, "dignity" meant staff  
were to carry out activities that assisted the  
patient to maintain and enhance his/her self  
esteem and self worth. Further review revealed  
staff should maintain patient privacy of body and  
ensure patients were sufficiently covered.

F 000 The statements made in this plan of  
correction are not an admission to and  
do not constitute an agreement with  
the alleged deficiencies herein. The  
Plan of Correction is prepared and  
executed solely because it is required  
by Federal and State law.

F 241

F241

Resident #3 was assessed by the Social  
Services Director on 7/2/15 for  
signs/symptoms of psychosocial concerns.  
Resident #3 exhibited no adverse  
outcome.

All residents have the potential to be  
affected.

Observations related to dignity to include  
closure of the privacy curtain during skin  
assessments were made by the Director of  
Nursing (DON) on 7/9/15, 7/10/15, and  
7/11/15 across three shifts with no  
additional concerns identified.

Re-education of Licensed Practical Nurse  
(LPN) #1 was completed by the DON on  
7/1/15 to ensure closure of the privacy  
curtain during a resident skin assessment.

Re-education of Licensed Nurses (LN)  
and Certified Nurse Aides (CNA) was  
initiated by the DON or Assistant Director  
of Nursing (ADON)/Nurse Practice

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

*Elizabeth Bennett*

TITLE

*Administrator*

(X6) DATE

*8/6/15*

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 241	<p>Continued From page 1</p> <p>Record review revealed the facility admitted Resident #3 on 12/08/12 with diagnosis which included Alzheimer's Disease, Adult Failure to Thrive, difficulty in walking and Depressive Disorder. Review of a quarterly Minimum Data Set (MDS) assessment, dated 04/29/15, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable.</p> <p>Observation of a wound assessment, on 07/01/15 at 11:10 AM, revealed Licensed Practical Nurse (LPN) #1 left open the door to the hallway, pulled the outer privacy curtain, donned gloves, and rolled Resident #3 to the right lateral position; and unfastened brief and assessed area of wound site. LPN #1 did not close the privacy curtain between Resident #3 and his/her roommate. Resident #3's roommate was sitting in a chair between the resident's beds and Resident #3 was in full view of his/her roommate. Resident #3's roommate stated he/she did not believe Resident #3 had a wound anymore.</p> <p>Interview with LPN #1, on 07/01/15 at 12:00 PM, revealed he began working at the facility in May 2015. The LPN said he should have pulled the <u>privacy curtains</u> between Resident #3 and his/her roommate prior to providing care.</p> <p>Interview with the Assistant Director of Nursing (ADON)/ Infection Control Nurse, on 07/01/15 at 2:00 PM, revealed staff should pull privacy curtains when providing resident care. In addition, the ADON said the failure to provide privacy during resident care was a dignity issue.</p>	F 241	<p>Educator (NPE) on 7/1/15 to ensure closure of the privacy curtain during a resident skin assessment. Posttests to be completed on or before 7/28/15 to validate understanding, with 100% pass rate. Staff not available during this time frame will be provided re-education including posttest upon return to work.</p> <p>DON, ADON/NPE, or Charge Nurse will observe skin assessments to ensure closure of privacy curtain daily across all shifts for two weeks, three times per week for four weeks across all shifts, and then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.</p> <p>The QIC is comprised of the <u>Administrator, DON, ADON, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, NPE, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.</u></p> <p>The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.</p> <p>Completion Date</p>	7/30/15

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F 241	Continued From page 2 Interview with the Director of Nursing (DON), on 07/02/15 at 12:15 PM, revealed privacy curtains should be used when needed to ensure a resident would not see care being provided to another resident.	F 241			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced	F 278	F278  An MDS correction was submitted by the Registered Nurse/Clinical Reimbursement Coordinator for Resident #2 on 7/1/15 related to locomotion (Section G0100 E). Resident #2 exhibited no adverse outcome.  All residents have the potential to be affected.  An audit related to Activities of Daily Living (ADL) Coding on comprehensive assessments of all residents from 3/1/15 to 7/6/15 was initiated by the Registered Nurse/Clinical Reimbursement Coordinator on 7/9/15, with corrective action if indicated.  Re-education of the Registered Nurse/Clinical Reimbursement Coordinator was completed by the Regional Clinical Reimbursement Manager on 7/1/15 regarding accurate coding of MDS. Posttest completed with 100% pass rate.  Administrator, Director of Nursing (DON), or Regional Clinical		

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F 278	Continued From page 3 by: Based on observation, interview, record review and review of Minimum Data Set (MDS) Resident Assessment Instrument (RAI) manual Version 3.0, it was determined the facility failed to ensure accuracy of an assessment related to inaccurate coding of the Minimum Data Set (MDS) assessment related to locomotion for one (1) of eleven (11) sampled residents (Resident #2).  The findings include:  Review of the RAI 3.0 Manual, dated May 2011, revealed when conducting an MDS Assessment staff were to speak with direct care staff from each shift who had cared for the resident to determine his/her needs. When reviewing records, interviewing staff and observing the resident staff conducting the MDS Assessment must be specific when evaluating each component as listed in the Activities of Daily Living (ADL) activity definition. Review of instructions for rule of three (3), revealed when any activity occurs three (3) times at any one level, code that level. Further review of the manual for Section G, the Functional Status section revealed Under Section G0100 E, Locomotion on Unit was defined as how resident moves between locations in his/her room and adjacent corridor on same floor and if in wheelchair, self sufficiency once in chair.  Record review revealed the facility admitted Resident #2 on 03/30/09 with diagnoses of Psychosis, Ulcerative Colitis, Congestive Heart Failure, Depression, Abdominal Pelvic Swelling, Hypertension, Anxiety, and Osteoarthritis. Review of Resident #2's annual MDS assessment, dated 06/15/15, revealed the facility	F 278	Reimbursement Manager will validate ADL coding on MDS assessments, Section G0100 E, prior to submission to ensure accuracy three times per week for four weeks, two times per week for one month, then as determined by the monthly Quality Improvement Committee (QIC) with corrective action if indicated. Findings will be reported to the Administrator.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.  The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.  Completion Date	7/30/15
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F 278	<p>Continued From page 4</p> <p>assessed Resident #2's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of Resident #2's MDS assessment, dated 12/07/14, revealed he/she was coded as needing only supervision for Section G0100-B (transfer). However, review of Resident #2's supportive documentation on the Resident Functional Performance Record for December 2014, revealed he/she required extensive assistance with one (1) person's physical assistance for transfers during the MDS look back period of 12/01/15 through 12/07/15 on three (3) occasions, which would result in a coding of extensive assistance for transfers.</p> <p>Review of Resident #2's MDS assessment, dated 03/09/15, revealed he/she was coded in Section G0110-E (locomotion on unit) as only needing supervision for locomotion on the unit. However, Resident #2 was coded in Section G0110-D (walk in corridor) as having had required limited assistance of one person for physical assist, which would result in a coding for limited assistance for locomotion on unit.</p> <p>Interview with MDS Coordinator RN #4, revealed Resident #2's MDS dated 12/07/14 had been coded inaccurately for section G0100-B (transfer) and that it should have been coded as extensive assistance and not supervision based on supportive documentation on the Resident Functional Performance Record for December 2014. The interview further revealed Resident #2's MDS dated 03/09/15 had been coded inaccurately for section G0110-E (locomotion on unit) and locomotion on unit should have been</p>	F 278			

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F 278	Continued From page 5 coded as limited assistance and not supervision.  Interview with facility Administrator, on 07/01/15 at 02:45 PM, revealed she expected the MDS assessments to be coded accurately and reflect the resident's true status.	F 278	<del>F281</del>  Registered Nurse (RN) #1 verified placement of the enteral tube placement prior to medication administration or flushes of Resident E on 7/1/15 with no adverse findings identified and validated by the Director of Nursing (DON).		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality related to checking placement of a percutaneous endoscopic gastrostomy (peg) tube prior to the administration of medication for one (1) unsampled resident (Resident E).  The findings include:  Review of the facility's policy and procedure, titled "Medication Administration: Enteral", revised 01/02/14, revealed prior to medication administration or flushes, peg tube placement should be verified.  Record review revealed the facility admitted Unsampled Resident E on 05/20/15 with diagnoses which included Anemia, Coronary Artery Disease, Hypertension, Gastro-esophageal Reflux; Cerebral Vascular Accident;	F 281	Re-education of RN #1 was completed by the DON on 7/3/15 to ensure verification of the enteral tube placement prior to medication administration or flushes.  All residents with an enteral tube have the potential to be affected.  Observations related to enteral tube placement verification prior to medication administration or flushes by Licensed Nurses (LN) were made by the Director of Nursing (DON), Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE), or Registered Nurse (RN) during enteral medication administration on 7/9/15, 7/10/15, and 7/11/15 across three shifts with no additional concerns identified.  Re-education of Licensed Nurses (LN) was initiated by the DON or ADON/Nurse Practice Educator (NPE) on 7/3/15 to ensure verification of enteral tube placement prior to medication administration or flushes. Posttests to be		

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F 281	Continued From page 6 Hypothyroidism; Anxiety, Depression, Manic Depression, and Respiratory Failure.  Observation of a medication pass for Unsampled Resident E, on 07/01/15 at 1:50 PM, revealed Registered Nurse (RN) #1 prepared the resident for medication administration by placing the feeding tube pump on hold and taking the peg tube apart in order to administer medications. Before RN #1 started to flush the peg tube, and when asked if he was going to check the peg tube for placement, he replied he had checked it earlier in the morning. When asked if the tube was supposed to be checked prior to medication administration each time, RN #1 replied he went by what was ordered on the Medication Administration Record (MAR) and if it revealed to check the tube placement once a shift, then that is what he did. However, review of Unsampled Resident E's July 2015 MAR revealed the tube was to be checked for proper placement prior to each feeding, flush, or medication administration.  Interview with the Director of Nursing (DON), on 07/02/15 at 12:20 PM, revealed she expected peg tube placement to be checked prior to medication administration and she was unsure of how the policy read on checking peg tube placement more than once a shift.	F 281	completed on or before 7/28/15 to validate understanding with 100% pass rate. Staff not available during this time frame will be provided re-education including posttest upon return to work.  DON, ADON/ NPE, or Charge Nurse will observe medication and/or flush administration via enteral tube upon completion of re-education with posttest to ensure verification of enteral tube placement prior to medication administration or flushes daily across all shifts for two weeks, then three times per week for two weeks across all shifts, one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC) with corrective action if indicated. Findings will be reported to the DON.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311	The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.		

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F 311 Continued From page 7

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure staff provided cues and supervision in the Restorative Dining Room for three (3) unsampled residents (Resident B, C, and D). Certified Nurse Aide (CNA) #2 was on her cell phone for approximately ten (10) minutes instead of providing supervision during the lunch meal for Restorative residents.

The findings include:

Review of facility's policy titled, "Personal Cell Phones and Handheld Devices: Use of", revealed it was the facility's policy that staff may not use cell phones, hand held devices or other forms of personal communication, image, audio, text and or computer devices when in patient care areas including patient rooms, dining areas, community rooms, and adjacent hallways, or while attending to in any area of the location.

Observation during the lunch meal, on 06/30/15 at 11:55 AM, revealed Certified Nursing Aide (CNA) #2 was in the restorative dining with three (3) residents (Unsampled Resident B, C, and D). CNA #2 kept her head down, with her cell phone on the table, using her cellular device for approximately ten (10) minutes while Resident's B, C and D were eating lunch. CNA #2 would not have been aware if a resident required cues or encouragement as she was not observing the residents. Registered Nurse (RN) #2 came into the room and witnessed what CNA #2 was doing.

Record review of Resident B, revealed his/her restorative plan showed he/she was placed in

F 311 Completion Date 7/30/15

F311

Re-education of Certified Nurse Aide #2 was completed by the Administrator in Training on 6/30/15 to 1) ensure that residents are observed and cued as ordered during restorative dining and 2) personal cellular phones are not in use in resident care areas.

All residents have the potential to be affected.

Observations related to 1) ensure that residents are observed and cued as ordered during restorative dining and 2) personal cellular phones are not in use in resident care areas were made by the Director of Nursing (DON) on 7/9/15, 7/10/15, and 7/11/15 across three shifts with no additional concerns identified.

Re-education of staff was initiated by the Administrator, DON, or Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) on 6/30/15 1) ensure that residents are observed and cued as ordered during restorative dining and 2) personal cellular phones are not in use in resident care areas. Posttests to be completed on or before 7/28/15 to

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F 311 Continued From page 8

restorative dining for tray set up and cues to be provided as needed due he/she was at risk for decreased eating and swallowing.

Record review of Resident C, revealed his/her restorative plan showed he/she was placed in restorative dining due to he/she required maximum verbal cues, encouragement, and increased time to complete.

Record review of Resident D, revealed his/her restorative plan showed he/she was placed in restorative dining for tray set up and cues as needed.

Interview with CNA #2, on 06/30/05 at 12:05 PM, revealed she was in charge of monitoring restorative residents during lunch and would not have been able to safely monitor the residents without providing visual supervision. The interview further revealed CNA #2 had received a text message on her cellular device that she responded to then started playing a game on her cellular device.

Interview with RN #2 on 06/30/15 at 12:05 PM, revealed he expected staff to not be on cellular devices during any resident care areas including restorative dining. He stated residents in restorative dining need supervision, monitoring, cueing and assistance at times and that it would not be appropriate for the staff to not be providing these interventions.

Interview with Restorative RN #3, on 07/01/15 at 9:00 AM, revealed she expected the restorative staff to be attentive and continuously monitor the residents in restorative dining. She stated it was inappropriate for staff to be on a cellular device

F 311 validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.

DON, ADON/ NPE, or Charge Nurse conduct observation rounds to ensure 1) ensure that residents are observed and cued as ordered during restorative dining and 2) personal cellular phones are not in use in resident care areas daily across all shifts for two weeks, three times per week for four weeks across all shifts, then weekly for two weeks, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the DON.

The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.

The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.

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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023		
(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 311	Continued From page 9 during restorative dining and the residents need the staff's full attention.  Interview with Director of Nursing (DON), on 07/01/15 at 9:10 AM, revealed she expected staff to not be on cellular devices in resident care areas or while providing care for residents and it was unacceptable for staff to not monitor residents during restorative dining.	F 311	<b>F323</b>  a) Wet Floor Sign was removed from Resident A by housekeeper on 7/1/15 and additional wet floor signs stored in appropriate area.  Re-education of Housekeeping Staff #6 and #11 was completed by the Housekeeping/Laundry Supervisor on 6/30/15 to ensure 1) to maintain a dry passageway when mopping, and 2) staff # 11 regarding the appropriate storage of wet floor signs on 7/1/15 respectively.  All residents have the potential to be affected.  Observations related to the 1) dry passage left when mopping, environment remaining free of accidents or hazards including wet floor sign usage and 2) medication carts remaining locked when out of sight were made by the Administrator, Director of Nursing (DON), or Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) on 7/9/15, 7/10/15, and 7/11/15 across three shifts with no additional concerns identified.  Re-education of Housekeeping/Laundry staff was initiated by the Administrator in Training or the Housekeeping/Laundry Supervisor on 6/30/15 to 1) maintain a		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible related to housekeeping mopping both sides of the hallway, wet floor signs not properly stored and medication carts left unlocked. Three (3) wet floor signs were left in front of Unsampled Resident A's room with unsampled Resident A in a wheelchair on top of a wet floor sign unable to propel wheelchair off of the wet floor sign and the housekeeper mopped the floor of the hall without leaving a dry passageway. In addition, two (2) licensed staff left medication carts unlocked when out of their sight.	F 323			

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F 323	<p>Continued From page 10</p> <p>The findings include:</p> <p>1. Review of the facility's guidelines titled, "Safety-Overview", dated 01/01/00, revealed housekeeping staff should know their safety responsibilities to include: safe use of provided equipment, to know and understand the safety rules and regulations applicable to the Housekeeping Department as well as other departments of the nursing home; and to watch for hazards and report them. In addition, new personnel must demonstrate the ability to use housekeeping equipment before being permitted to operate it in a resident area. Further review revealed a policy titled "Floor Care", dated 01/01/00, revealed areas were to be mopped so there was a dry passageway. Half of a corridor should always be free for traffic. All equipment should stand in the section being cleaned. In addition, staff were to make sure wet areas were marked. "Wet Floor" signs should be placed at the beginning, middle, and end of the section being mopped. Such signs should be displayed whenever floors were washed, waxed, sealed, or stripped. Further review revealed nursing home staff and residents must be aware of a wet hallway floor when exiting a room or turning a hallway corner. Wet floor signs MUST be displayed to help avoid an accident.</p> <p>Observation on 06/30/15 at 11:05 AM, revealed Housekeeping Staff #6 mopping both sides of the hallway floor, wet floor caution sign was in the middle of the hallway.</p> <p>Interview with Housekeeping Staff #6, on 07/01/15 at 2:00 PM, revealed she began working at the facility one (1) week prior and had been</p>	F 323	<p>dry passage way when mopping and 2) the appropriate storage of wet floor signs. Posttests to be completed on or before 7/28/15 to validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.</p> <p>Administrator or Housekeeping/Laundry Supervisor will observe for dry passage during mopping and wet floor sign placement to ensure safety across all shifts daily for two weeks, three times per week for two weeks across all shifts, and then one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.</p> <p>The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.</p> <p>The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.</p>	
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F 323	<p>Continued From page 11</p> <p>mopping the hallway, placing the wet floor sign but had not been leaving a dry passageway. Housekeeping Staff #6 said she spoke with her supervisor the day prior and was told to only mop one (1) side of the hallway and to leave a dry passageway.</p> <p>Interview with the Housekeeping/Laundry Supervisor, on 07/01/15 at 2:15 PM, revealed Housekeeping Staff #6 was a new employee and began working at the facility one (1) week prior. The supervisor said the hallways should be mopped leaving a dry passageway for staff and residents safe use.</p> <p>2. Observation of Unsampled Resident A, on 07/01/15 at 09:05 AM, revealed he/she was in a wheelchair in the doorway to his/her room and there was a wet floor sign under the wheelchair and three (3) other wet floor signs leaned up against the wall next to Resident A's door. Resident #A attempted to move forwards and backwards off of the wet floor sign and was unable to. Resident A attempted to bend over, while in the wheelchair, to attempt to dislodge the wet floor sign several times.</p> <p>Interview, on 07/01/15 at 9:15 AM with Housekeeper #11, revealed she would expect the wet floor signs to be stored on the housekeeping carts or in the appropriate storage closets after the floors were dry and that it was a hazard to place the unused wet floor signs up against the wall next to a resident's door frame. She further stated this could cause a resident to have a fall or injury.</p> <p>Interview, on 07/01/15 at 9:20 AM with Housekeeping Supervisor #9, revealed she</p>	F 323	<p>b) Medication carts were locked upon discovery by Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 on 7/1/15.</p> <p>Re-education of LPN #1 and RN #2 was completed by the Director of Nursing (DON) on 7/1/15 to ensure drugs and biologicals are stored in a locked cabinet/cart when not in Licensed Nurse (LN) direct line of vision.</p> <p>All residents have the potential to be affected.</p> <p>Observations related to ensure the medication carts remained locked when out of sight were made by the Administrator, DON, or ADON on 7/9/15, 7/10/15, and 7/11/15 across three shifts with no additional concerns identified.</p> <p>Re-education of LNs was initiated by DON or Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) on 7/1/15 to ensure drugs and biologicals are stored in a locked cabinet/cart when not in LNs direct line of vision. Posttests to be completed on or before 7/28/15 to validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.</p>	

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F 323	<p>Continued From page 12</p> <p>expected staff to properly store wet floor signs in the appropriate places when not in use and it was unacceptable for staff to place unused wet floor signs up against walls and or near resident room which could cause the resident's to have a fall or injury if they bumped into them or tripped over them.</p> <p>Interview, on 07/01/15 at 09:40 AM with Administrator in Training #3, revealed she expected staff to properly store wet floor signs in the appropriate places when not in use to prevent accidents and injuries.</p> <p>3. Review of facility policy "Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles", revised 05/16/11, revealed drugs and biologicals, including treatment items, should be securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and visitors.</p> <p>Observation of the one hundred (100) hall Medication Cart on 7/01/15 at 10:55 AM, revealed Licensed Practical Nurse (LPN) #1 left the medication cart unlocked and unsecured while taking medication to a resident around the corner from where the medication care was located. Interview with LPN #1 at the time, revealed the medication carts were supposed to be locked when the person using the cart leaves the area the cart was in.</p> <p>Observation of three hundred (300) hall Medication Cart, on 7/01/15 at 11:50 AM, revealed Registered Nurse (RN) #2 left the medication cart unlocked and unsecured outside of the nursing station while he was sitting behind the nursing station with the inability to monitor the</p>	F 323	<p>DON, ADON/NPE, or Charge Nurse will observe medication carts to ensure carts are locked when not in direct line of vision daily across all shifts for two weeks, three times per week for two weeks across all shifts, one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the DON.</p> <p>The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.</p> <p>The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.</p> <p>Completion Date</p> <p>F371</p> <p>Immediate re-education was provided to the Dietary Chef by the Director of Dining Services on 7/1/15 to include changing gloves and hand washing.</p>	7/30/15

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F 323	Continued From page 13 medication cart. Interview with RN #2, on 07/01/15 at 11:50 AM, revealed he expected the medication cart to be locked.  Interview with Director of Nursing (DON), on 07/02/15 at 12:50 PM, revealed she expected licensed staff to make sure the medication carts were locked and secured when they leave the area the medication cart was in.	F 323	All residents have the potential to be affected.  Tray line observations were conducted during meal service by the Director of Dining Services 7/3/15 through 7/10/15 with no additional concerns identified.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was served under sanitary conditions as evidenced by a Dietary Chef not changing gloves and not washing hands after six (6) observations of tray line being broken.  Review of the Census and Condition, dated 06/30/15, revealed there were forty-three (43) residents in the building and three (3) residents with tube feedings.	F 371	Re-education of Dietary staff was completed by the Director of Dining Services on 7/1/15 to ensure proper changing of gloves and hand washing to maintain sanitary conditions. Posttests to be completed on or before 7/28/15 to validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.  Administrator or Director of Dining Services will observe tray line during meal service to ensure proper changing of gloves and hand washing to maintain sanitary conditions daily for two weeks across all shifts, then three times per week for two weeks across all shifts, one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC) with corrective action as indicated. Findings will be reported to the Administrator.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business	

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F 371	<p>Continued From page 14</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled, "Food Handling", last revised 03/16/15, revealed "Employees wash hands frequently and wear disposable gloves when handling food. Disposable gloves are considered a single use item and are changed after each use".</p> <p>Review of the facility's policy and procedure, titled "Disposable Glove Use", not dated, revealed "Glove use follows the same principle as hand washing, change anytime you change task or touch possible contaminated items.</p> <p>Observation of tray line service during a lunch meal, on 07/01/15 at 11:40 AM, revealed the Dietary Chef broke tray line six (6) times during tray line meal pass. He left the tray line to go to the refrigerator and to the freezer and returned to the tray line and did not change his gloves or wash his hands.</p> <p>Interview with the Dietary Chef, on 07/01/15 at 2:45 PM, revealed anytime activities were changed during tray line, gloves should have been changed and hands washed due to possibility of contaminating the food.</p> <p>Interview with Dietary Manager, on 07/01/15 at 3:13 PM, revealed she expected for anyone working the tray line to wash their hands and change their gloves if the tray line was broken for any reason.</p> <p>Interview with the Administrator in Training, on 07/02/15 at 9:45 AM, revealed she expected the Chef or anyone else working the tray line to</p>	F 371	<p>Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.</p> <p>The Director of Dining Services or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.</p> <p>Completion Date</p> <p>F431</p> <p>One bottle of Magnesium Citrate was discarded by the DON on 7/2/15. Fifty-four bottles of liquid and powder medications were dated by the Director of Nursing (DON) that were delivered within the past thirty days by the pharmacy by 7/2/15.</p> <p>All residents have the potential to be affected.</p> <p>Observations were completed by the Director of Nursing (DON) to ensure no additional bottled liquid or powered medications were not dated upon opening on 7/2/15 of all medication carts with no additional concerns identified.</p> <p>Re-education of Licensed Nurses (LN)</p>	7/30/15

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F 371	Continued From page 15 change their gloves and wash their hands if the tray line was broken.	F 371	was initiated by the DON, Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE), or Registered	
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 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.  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.	F 431	Nurse (RN) on 7/2/15 on to ensure that bottles of liquid medication and containers of powdered medication are dated upon opening. Posttests to be completed on or before 7/28/15 to validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.  DON, ADON/NPE, or Charge Nurse will observe medication carts for undated/unlabeled medication daily across all shifts for two weeks, three times per week for two weeks across all shifts, then one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the DON.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.  The DON or Administrator will report findings to the monthly QIC for three	

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F 431	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure labeling of drugs related to bottles of liquid medication and containers of powdered medication not being dated when opened in all four (4) of four (4) of the facility's medication carts. Observation revealed thirty-two (32) bottles of liquid and twenty-one (21) containers of powdered medications not being labeled after being opened.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles", last revised 05/16/11, revealed once any drug or biological was opened, the facility should follow manufacturer/supplier guidelines for in use expiration dating.</p> <p>Observation of the medication carts on Hall one hundred (100), Hall two hundred (200), and Hall three hundred (300), on 07/02/15 at 12:30 PM and 12:45 PM, revealed multiple open bottles of liquid medication and containers of powdered medications not dated when opened: eight (8) bottles of Milk of Magnesia (laxative), four (4) bottles of Mylanta (antacid), ten (10) bottles of Q-Tussin (cough suppressant), one (1) bottle of Mag Citrate (laxative), two (2) bottles of Robafen (cough suppressant), one bottle of Mapap (pain reliever/fever reducer), one (1) bottle of Multi Delyn (multi vitamin), one (1) bottle of Lactulose</p>	F 431	<p>months for any additional follow up and/or educational needs.</p> <p>Completion Date 7/30/15</p> <p>F441</p> <p>1) Resident #3 was assessed by the Director of Nursing (DON) on 7/1/15 for signs/symptoms of infection related to ensuring proper hand washing after a resident skin assessment. No adverse outcomes were identified.</p> <p>Re-education of Licensed Practical Nurse (LPN) #1 was completed by the DON on 7/1/15 to ensure appropriate hand hygiene technique during a skin inspection, with a posttest to validate understanding.</p> <p>All residents have the potential to be affected.</p> <p>Observations related to proper hand hygiene were made by the DON on 7/9/15, 7/10/15, and 7/11/15 across three shifts with no additional concerns identified.</p> <p>Re-education of Licensed Nurses was initiated by the DON or Assistant Director of Nursing (ADON)/Nurse Practice Educator (NPE) on 7/1/15 to ensure</p>	7/30/15

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F 431	Continued From page 17 (colonic acidifier-treat constipation), one bottle of Lidocaine HCL (local anesthetic), one (1) bottle of Guaifenesin (expectorant), one (1) bottle of Loratadine (antihistamine), fourteen (14) containers of Miralax (laxative), one (1) container of Nystatin (anti mycotic), six (6) containers of Polyethylene Glycol (laxative).  Interview with RN #2, on 07/02/15 at 12:45 PM, revealed he was unaware that bottles of liquid medication and containers of powdered medication should be dated when opened in regards to tracking and monitoring for expiration dates.  Interview with Unit Manager #7, on 07/02/15 at 12:45 PM, revealed the facility staff should record the date opened on the medication bottle and/or container when the medication has a shortened expiration date once opened; otherwise, staff would be unable to determine when the expiration date was if it was not dated upon opening.  Interview with the Director of Nursing (DON), on 07/02/15 at 12:50 PM, revealed she expected staff to date bottles of liquid medication and containers of powdered medication when opened.	F 431	appropriate hand hygiene occurs as indicated with skin inspections. Posttests to be completed on or before 7/28/15 to validate understanding. Staff not available during this time frame will be provided re-education including posttest upon return to work.  DON, ADON/NPE, or Charge Nurse will observe hand hygiene across all shifts to ensure proper hand washing after skin assessments daily across all shifts for two weeks, then three times per week for two weeks across all shifts, one time per month for two months, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the DON.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.	
F 441 SS=D	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	F 441	The DON or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.  2) All residents have the potential to be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, 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 policy and Laundry Protocol it was determined the facility failed to maintain an Infection Control Program to help prevent the development and transmission of disease and infection. Licensed Practical Nurse (LPN) #1	F 441	affected.  The Administrator re-educated Housekeeping/Laundry Supervisor on proper folding techniques and proper apron usage on 7/1/15 with a posttest to validate understanding.  The Housekeeping/Laundry Supervisor immediately re-educated the Housekeeping/Laundry Staff #6 regarding proper folding techniques and proper apron usage on 7/1/15 with a posttest to validate understanding.  Observations related to laundry services including folding and use of aprons were made by the Administrator or Housekeeping/Laundry Supervisor on 7/9/15, 7/10/15, and 7/11/15 with no additional concerns identified.  Re-education of Housekeeping/Laundry staff was initiated by the Administrator or Housekeeping/Laundry Supervisor on 7/1/15 to ensure appropriate linen handling and apron use with posttest to validate understanding on 7/7/15.  The Administrator or Housekeeping/Laundry Supervisor will observe folding of laundry to ensure appropriate technique and use of apron daily for two weeks, three times per week for two weeks across all shifts, one time	

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F 441	<p>Continued From page 19</p> <p>failed to wash his hands after removing his gloves following a wound assessment for one (1) of eleven (11) sampled residents (Resident #3). In addition, observations revealed the Laundry/Housekeeping Supervisor touched the floor with the clean linen that she was folding. Further observation on 07/01/15 at 11:30 AM, revealed Laundry/Housekeeping Staff #6 used her chin when folding clean linen. Neither staff were wearing aprons at the time.</p> <p>The findings include:</p> <p>1: Review of the facility policy titled, "Infection Control Policies and Procedures, Hand Hygiene", last revised 10/01/13, revealed personnel should wash hands with soap and water when hands were visibly soiled and use alcohol based hand rub for routine decontamination in clinical situations. Further review revealed staff should wash hands with soap and water or use an alcohol based hand rub after removing gloves or other personal protective equipment.</p> <p>Record review revealed the facility admitted Resident #3 on 12/08/12 with diagnoses which included Alzheimer's Disease, Adult Failure to Thrive, difficulty in walking and Depressive Disorder.</p> <p>Observation of a wound assessment, on 07/01/15 at 11:10 AM, revealed LPN #1 donned gloves, rolled Resident #3 to the right lateral position, unfastened brief and assessed area of wound site. LPN #1 refastened the brief, pulled up the covers, removed and threw away her gloves and walked to the nurses station without washing or sanitizing her hands. Further observation revealed LPN #1 then touched a</p>	F 441	<p>per month for two months, then as determined by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.</p> <p>The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.</p> <p>The Housekeeping/Laundry Supervisor or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.</p> <p>Completion Date</p>	7/30/15

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F 441	<p>Continued From page 20</p> <p>chart binder, skin assessment binder and medication cart.</p> <p>Interview with LPN #1 on 07/01/15 at 12:00 PM, revealed he should have washed hands after removing gloves.</p> <p>Interview with the ADON on 07/07/15 at 2:00 PM, revealed staff should wash hands after removal of gloves.</p> <p>Interview with the DON on 07/02/15 at 12:15 PM, revealed staff should wash hands after removal of gloves and before touching any other items.</p> <p>2. Review of the contracted Laundry and Housekeeping service policy, "Laundry", last revised 01/01/00, revealed aprons should be worn when working with both soiled and clean linen.</p> <p>Review of the "Laundry Unit Inspection", not dated, revealed linen should not touch the floor and linen should not be pressed against a staff members body to be folded.</p> <p>Observation on 06/30/15 at 1:15 PM revealed the Housekeeping/Laundry Supervisor folded laundry without wearing an apron. Further observation revealed a corner of the linen touched the floor of the laundry room while the supervisor folded the laundry.</p> <p>Observation on 07/01/15 at 11:30 AM revealed a staff member folded laundry without wearing an apron. Further observation revealed the staff member folded clean linen while holding a corner of the linen beneath her chin.</p>	F 441		

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F 441	Continued From page 21 Interview with the Housekeeping/Laundry Supervisor, on 07/01/15 at 2:00 PM, revealed the staff member working in the laundry room was "new" and had not been trained on the laundry process. The Supervisor said the new staff member was "helping me out" this morning. In addition, the Supervisor said staff should wear aprons when working with linen and clean laundry should not touch the floor or a staff members body.	F 441		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1993, with twenty-five (25) smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1993.</p> <p>GENERATOR: Type II generator installed in 1993. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/02/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty-three (53) beds with a census of forty-two (42) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The Plan of Correction is prepared and executed solely because it is required by Federal and State law.</p>	

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

*Elisabeth Bennett*

TITLE

*Administrator*

(X6) DATE

*8/16/15*

A 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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K 000	Continued From page 1	K 000	K025	
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, fifty-three (53) residents, staff and visitors. The facility has the capacity for fifty-three (53) beds and at the time of the survey, the census was forty-two (42).</p> <p>The findings include:</p> <p>1. Observation, on 07/02/15 at 9:15 AM, with the Maintenance Supervisor revealed an unsealed penetration in the smoke barrier extending above ---</p>	K 025	<p>Maintenance Director filled in unsealed penetration in the smoke barrier extending above the ceiling located in the Personal Care Hall and in the smoke barrier extending above the ceiling located in the 300 Hall on 7/2/15.</p> <p>Maintenance Director inspected all smoke barriers in the attic 7/2/15 with no other penetrations identified.</p> <p>Re-education of Maintenance Director was completed by Administrator on 7/3/15 on NFPA code to maintain smoke/fire rated walls from penetrations with a posttest to validate understanding.</p> <p>Administrator or Maintenance Director will validate safety with audits of smoke/fire rated walls one time per month for three months, then returning to quarterly inspections. Findings will be reviewed by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.</p> <p>The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity</p>	

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K 025	Continued From page 2 the ceiling located in the Personal Care Hall. The penetration was due to a continuous ridge vent that was recently installed with the new roof.  Interview, on 07/02/15 at 9:16 AM, with the Maintenance Supervisor revealed he was not aware the smoke barrier would not resist the passage of smoke due to the new ridge vent.  2. Observation, on 07/02/15 at 9:20 AM, with the Maintenance Supervisor revealed an unsealed penetration in the smoke barrier extending above the ceiling located in the 300 Hall. The penetration was due to a continuous ridge vent that was recently installed with the new roof.  Interview, on 07/02/15 at 9:21 AM, with the Maintenance Supervisor revealed he was not aware the smoke barrier would not resist the passage of smoke due to the new ridge vent.	K 025	Director, Food Service Director, and Maintenance Director.  The Maintenance Director or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.  Completion Date	7/30/15
	The census of forty-two (42) was verified by the Administrator on 07/02/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/02/15.  Actual NFPA Standard:			
	Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided			

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K 025	Continued From page 3 on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.  Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K051  Maintenance Director installed battery powered smoke detector for temporary protection on 7/2/15 in the electrical room.  Contractor was hired to install a hard-wired smoke detector attached to the fire panel on 7/22/15.  All residents have the potential to be affected.  Re-education of Maintenance Director was completed by Administrator on 7/3/15 on NFPA code for smoke detector placement, with a posttest to validate understanding.  Administrator or Maintenance Director will validate that the smoke detector is in proper working order daily until hard wire smoke detector installed, then one time per month for three months, then returning to quarterly inspections. Findings will be reviewed by the Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to	K 051	The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement	

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K 051 Continued From page 4  
NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6

K 051 Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.  
  
The Maintenance Director or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.

Completion Date

7/30/15

This STANDARD is not met as evidenced by:  
Based on fire alarm testing record review and interview, it was determined the facility failed to ensure the fire alarm control unit was protected in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, fifty-three (53) residents, staff and visitors. The facility has the capacity for fifty-three (53) beds and at the time of the survey, the census was forty-two (42).

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K 051	Continued From page 6 The findings include:  Observation, on 07/02/15 at 10:30 AM, with the Maintenance Supervisor revealed the main fire alarm control unit was located in an electrical room that was not continuously occupied. The electrical room was not equipped with smoke or heat detection.  Interview, on 07/02/15 at 10:31 AM with the Maintenance Supervisor revealed he was not aware of the requirement.  The census of forty-two (42) was verified by the Administrator on 07/02/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/02/15.  Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.  NFPA 72 (1999 Edition) 1-5.6* Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be provided. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 051	K056  A professional contractor company was contracted 7/3/15 to install two missing sprinkler heads on 7/29/15.  Maintenance Director observed all exterior overhangs on 7/3/15 for any other areas not protected by sprinkler coverage. No additional concerns identified.  Re-education of Maintenance Director was completed by Administrator on 7/3/15 on NFPA code for sprinkler coverage, with a posttest to validate understanding.  Administrator or Maintenance Director will validate placement of sprinkler heads one time per month for three months, then returning to quarterly inspections. Findings will be reviewed by the monthly Quality Improvement Committee (QIC), with corrective action as indicated. Findings will be reported to the Administrator.  The QIC is comprised of the Administrator, DON, Assistant Director of Nursing, Medical Director, Business Office Manager, Clinical Reimbursement Coordinator, Nurse Practice Educator, Unit Manager, Social Worker, Activity Director, Food Service Director, and Maintenance Director.	
K 056 SS=D		K 056		

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K 056

Continued From page 6

installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for fifty-three (53) beds and at the time of the survey, the census was forty-two (42). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.

The findings include:

Observation, on 07/02/15 at 11:02 AM, with the Maintenance Supervisor revealed a porch roof extending off the front of the building over the drive that was fully sprinkled; however two (2) existing porch extensions from the main porch did not have sprinkler protection. The porches were

K 056

The Maintenance Director or Administrator will report findings to the monthly QIC for three months for any additional follow up and/or educational needs.

Completion Date

7/30/15

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

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185382	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/02/2015
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 056	<p>Continued From page 7</p> <p>constructed of combustible wood framing and exceeded four (4) feet in width.</p> <p>Interview, on 07/02/15 at 11:01 PM, with the Maintenance Supervisor revealed they had been talked about before; however not aware of the reason they did not have sprinkler protection.</p> <p>The census of forty-two (42) was verified by the Administrator on 07/02/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/02/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056		
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