

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

PRINTED: 09/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 annual survey was conducted on 08/02/11 through 08/04/11 and a Life Safety Code survey was conducted on 08/04/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F."	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	The physician for resident #4 was notified of the abnormal lab on 7-26-11 by Registered Nurse. No new orders were given. Director of Nursing reviewed all labs, 24 hour reports and reports of incidents for past 30 days to ensure any noted change in condition was communicated to the MD. Registered Nurse educated Licensed Practical Nurse #4 regarding MD notification of labs 8-8-11. Nurse #4 had additional education on the procedure for physician notification in regards to labs on 8-25-11 by Registered Nurse. An in-service for all licensed staff will be conducted on 8-29 & 8-31-11 by	9-1-11	

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

TITLE

(X6) DATE

Patricia B. Donald, Administrator

9-12-11

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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy/procedure, and interviews, it was determined the facility failed to consult with the resident's physician in a timely manner for one resident (#4), in the selected sample of 18, related to a significant change in the resident's physical, mental, or psychosocial status. Abnormal lab values were received on 07/21/11 and the resident had recent abnormal lab values on 07/14/11. The results of the 07/21/11 abnormal labs were faxed five days later, on 07/26/11, and the physician was not contacted to obtain direction.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Notification of Physicians," undated, revealed "Physicians were to supervise the medical care of the residents and the staff were to assure the physician was informed of changes in the resident's condition...The following are, but not limited to, those conditions which should be communicated to the physician: all abnormal lab results that were to be faxed should be followed up with a phone call."</p> <p>A record review revealed Resident #4 was admitted to the facility on 07/17/09, with diagnoses to include Atrial Fibrillation, Dementia, and History of Cerebral Vascular</p>	F 157	<p>Director of Nursing. The in-service will cover proper notification of physicians regarding any change in resident condition, as well as the current system for lab tracking.</p> <p>Director of Nursing will review lab reports, 24 hour reports and all reports of incidents weekly for one month to ensure that Medical Doctor notification occurred when indicated. Any concerns will be addressed with physician and appropriate nurse immediately upon finding. Director of Nursing will report findings to the Quality Assurance committee monthly for two months.</p>	9-1-11	

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F 157	<p>Continued From page 2</p> <p>Accident/Transient Ischemic Attack.</p> <p>A review of Resident #4's lab results, dated 07/14/11, revealed a critical Red Blood Cell count of 2.99 cells/microliter (normal range: 3.90-5.50 cells/uL), a low Hemoglobin of 8.4 grams/deciliter (normal range: 12-16 g/dl), and a low Hematocrit of 25.7 percent (normal range: 37-47 percent). The physician was consulted on 07/14/11 with orders to repeat a Complete Blood Count one week later, on 07/21/11.</p> <p>A review of the lab results, dated 07/21/11, revealed a low Red Blood Cell count of 3.24 cells/uL, a low Hemoglobin of 9.1 g/dl, and a low Hematocrit of 27.8 percent, with a fax date of 07/26/11. There was no evidence the facility consulted with the physician regarding the abnormal results until five days later.</p> <p>A review of the laboratory's Result Delivery Log, dated 07/21/11, revealed the results were faxed to the facility on 07/21/11 at 12:14 PM, and was re-faxed on 07/26/11 at 8:08 AM.</p> <p>An interview with Registered Nurse (RN) #3, on 08/04/11 at 10:53 AM, revealed panic levels were supposed to be called to the physician, but abnormal lab values were faxed to the physician. If the physician did not contact the facility within a couple of days, the facility contacted the physician.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 08/03/11 at 3:35 PM, revealed all specimens were logged on a communication sheet for monitoring to ensure results were received. It was the charge nurse's responsibility</p>	F 157		9-1-11	

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F 157	Continued From page 3 to ensure labs were followed up once they were obtained. An interview with the Director of Nursing (DON), on 08/04/11 at 1:46 PM, revealed there was a form the nurse initialed after receipt of laboratory results and after faxing the physician. The form revealed LPN #4 received the laboratory results on 07/21/11, but there were no initials to indicate the results were faxed to the physician. She expected the nurse to document after contacting the physician. She was unable to produce documentation the physician was notified of the lab values received on 07/21/11. An interview with the Advanced Registered Nurse Practitioner (ARNP), on 08/04/11 at 2:05 PM, revealed the laboratory called only if a critical lab value was received. A window of 48-72 hours would be a reasonable time frame to fax the physician with abnormal lab values. An interview with Resident #4's physician, on 08/04/11 at 1:32 PM, was attempted, but the physician was unavailable.	F 157		9-1-11
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF 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, record review and	F 241	It is the practice of this facility to provide care to our residents in a manner and environment that maintains residents' dignity and respect in full recognition of his or her individuality. Plan of correction will correct for resident #3, current and new residents. Nurse #4 was re-educated on the need to provide privacy to residents	9-1-11

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F 241	<p>Continued From page 4</p> <p>interview, it was determined the facility failed to promote care in a way which maintained or enhanced a resident's dignity and respect, related to the failure to close the bedroom door, close the window blinds or the privacy curtains, during a skin assessment for one resident (#3), in the select sample of 18.</p> <p>The findings include:</p> <p>A record review revealed Resident #3 was admitted to the facility on 07/22/09 with diagnoses to include Chronic Obstructive Pulmonary Disease, Chronic Renal Failure and History of Mediastinal Adenopathy and Cancer.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 07/05/11, and the care plan "Activities of Daily Living", dated 07/13/11, revealed the resident was extremely hard of hearing, was recently hospitalized for recurrent bouts of pneumonia and required assistance of one staff member with bed mobility and transfers.</p> <p>An observation during a skin assessment for Resident #3, on 08/03/11 at 8:28 AM, revealed Licensed Practical Nurse (LPN) #4 did not close the door, the window blinds or pull the curtains around Resident #3 during the assessment for bruising or pressure areas.</p> <p>An interview with LPN #4, on 08/03/11 at 8:45 AM, revealed "I was nervous and just forgot" about provision of privacy for the resident.</p> <p>An interview with the Director of Nursing (DON), on 08/04/11 at 2:48 PM, revealed the DON expected the LPN to provide privacy for Resident</p>	F 241	<p>during care on 8-3-11 by the Director of Nursing.</p> <p>Routine observations of care practices are made daily by nursing staff and there have been no noted problems in regards to privacy. Social Services reviewed grievances and resident council notes for last three months on 8-22-11 to determine if there have been any complaints regarding privacy and none have been noted.</p> <p>Director of Nursing provided education for all nursing staff on 8-29 & 8-31-11 to ensure visual privacy for residents during care, the blinds need to be closed, curtains pulled and doors closed. This will also be covered in the bi-annual in-service on resident rights as well as on orientation of all new employees.</p> <p>Director of Nursing or a designated nurse will monitor the practice of providing privacy by observing personal care for three residents per hall on each shift two times per week for two weeks, then weekly for four weeks, ensuring that each nursing assistant and nurse is</p>	9-1-11

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F 241	Continued From page 5 #3 by closing the blinds and shutting the door. This teaching was included, for all staff members, upon orientation to the facility during "Resident Rights Training" and during bi-annual inservicing.	F 241	observed at least once. Any concerns will be corrected immediately upon observation. These audits when completed will be incorporated into the facility Quality Assurance program.	9-1-11	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to develop a comprehensive plan of care for one resident (#12), in the selected sample of 18, related to Dysphagia (difficulty swallowing).				

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F 279	Continued From page 6 The findings include: The facility provided no policy in regard to resident care plans. A record review revealed Resident #12 was admitted to the facility on 10/09/09 with a diagnosis of Dysphagia. A review of the annual Minimum Data Set (MDS), dated 06/20/11, revealed the facility identified the resident to be severely cognitively impaired and required set up help and supervision while eating. A review of the "Nutrition Assessment," dated 06/23/11, revealed the resident's diet included mechanical soft with ground meats. The assessment revealed there was a history of dysphagia with no problem chewing or swallowing with diet texture modifications. A review of the Comprehensive Care Plan, revised 06/27/11, revealed the resident was at risk for unplanned weight loss and dehydration related to receiving a mechanically altered and therapeutic diet. There was no evidence on the care plans to address the resident's difficulty swallowing. A review of the "Daily Nursing Assistant Care Plan", dated 08/11, revealed the resident's diet included mechanical soft with ground meats and to cue small sips. A review of the physician's orders, dated 08/11, revealed an order for a mechanical soft diet with ground meats.	F 279	Resident #12 comprehensive care plan was reviewed and updated to reflect history of dysphagia on 8-4-11 by MDS. Speech therapy screened resident on 8-19-11 and found no problems with swallowing and notes resident is not at risk for choking and no swallowing interventions were needed. MDS Coordinator reviewed care plans on 8-22 to 8-25-11 to ensure that residents' individual needs were addressed. Specific attention was given to those residents with history of dysphagia and swallowing or choking issues. Care plans were revised as indicated. Care plans will continue to be developed to reflect the residents' individual problems, with measurable objectives and timetables to meet the residents' medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.	9-1-11	

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F 279	Continued From page 7 An interview with the Registered Dietician, on 08/04/11 at 2:10 PM, revealed if a resident did not have a current problem with swallowing, it would not be addressed on the care plan. An interview with the MDS Coordinator, on 08/04/11 at 2:00 PM, revealed the plan of care should address the resident's difficulty swallowing because the resident was at risk for choking. An interview with the Director of Nursing (DON), on 08/04/11 at 2:30 PM, revealed even if a resident tolerated his/her mechanically altered diet, he/she would still be at risk for choking.	F 279	Director of Nursing will review five care plans weekly for four weeks, then 10 per month for three months to ensure resident individual needs are being addressed and will specifically look for residents with swallowing or choking issues. Any issues will be corrected immediately upon finding.	9-1-11	
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 observations, record reviews and interviews, it was determined the facility failed to meet professional standards of quality for one resident (#4), in the selected sample of 18, related to ensuring physician's orders were implemented. A physician's order was in place for application of TED hose (antiembolic stockings); however, observations and interviews revealed the TED hose were not utilized for the resident. The findings include: A record review revealed Resident #4 was admitted to the facility on 07/17/09 with diagnoses	F 281	Resident # 4 TED hose were discontinued on 8-4-11. Comprehensive and nurse aide care plan were revised by Registered Nurse to reflect this change. Charge Nurse reviewed all comprehensive and nurse aide care plans on 8-31-11 to ensure physician's orders related to care were implemented. In-service for all staff will be presented by Director of Nursing on 8-29 & 8-31-11 to re-educate staff on importance of implementing physician orders and keeping care	9-1-11	

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F 281	Continued From page 8 to include Atrial Fibrillation, Dementia and History of Cerebral Vascular Accident/Transient Ischemic Attack. A review of Resident #4's quarterly Minimum Data Set (MDS), dated 06/24/11, revealed the facility identified Resident #4 to be severely cognitively impaired and required assistance for all activities of daily living. A review of physician's orders, dated 08/11, revealed an order for "thigh high TED hose- on in the AM, off at HS." Observations, on 08/03/11 at 7:46 AM, 9:20 AM, 10:10 AM, 11:25 AM, and 3:05 PM, and on 08/04/11 at 8:20 AM, revealed TED hose were not in place for Resident #4. Interviews with Certified Nurse Aides (CNAs) #7, #2, #3, and #9, on 08/04/11 at 9:13 AM, 9:27 AM, 9:43 AM, and 11:30 AM, respectively, revealed Resident #4 did not utilize TED hose. An interview with Registered Nurse (RN) #1, on 08/04/11 at 10:03 AM, revealed a physician's order was in place for the TED hose; however, no one contacted the physician for non-use until today (08/04/11), and received a discontinuation order. An interview with the Director of Nursing (DON), on 08/04/11 at 2:55 PM and 3:45 PM, revealed she expected the staff to follow written physician's orders. Additionally, she expected the nurses to consult with the resident's physician if a resident refused treatment.	F 281	plans accurate. In-service will also address importance of reviewing and following care plans daily. Charge nurse will review three care plans per shift three times per week for 2 weeks, then weekly for one month to ensure care plans are reflective of physician's orders, and are being followed. Charge Nurse will interview assigned staff to ensure the resident is compliant with orders. Physicians will be notified of resident non-compliance when noted, so appropriate action can be taken. These audits will then be included in the facility Quality Assurance program.	9-1-11	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED				

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F 282 SS=D	<p>Continued From page 9 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for two residents (#4 and #9), in the selected sample of 18. Resident #4 was care planned for the application of TED hose (Antiembolic Stockings); however, observations and interviews revealed the TED hose were not utilized for the resident. Resident #9 had an intervention in place to ensure the resident's rolling walker was stored in the shower room when not in use; however, observations and interviews revealed the intervention was not implemented.</p> <p>The findings Include:</p> <p>A review of the policy "Falls Management," dated 01/01/10, revealed "the facility implemented and monitored interventions to reduce risk factors which placed a resident at risk for falls."</p> <p>1. A record review revealed Resident #9 was admitted to the facility on 02/27/06 with diagnoses to include a Fractured Femur, Osteoarthritis and Joint Pain.</p> <p>A review of the quarterly Minimum Data Set</p>	F 282	<p>Resident # 4 TED hose were discontinued on 8-4-11.</p> <p>Comprehensive and nurse aide care plan were revised by Registered Nurse to reflect this change. The walker for Resident #9 is now placed in the shower room per the care plan.</p> <p>Charge Nurse will review all comprehensive and nurse aide care plans to ensure accuracy on 8-25 to 8-31-11. Care plans are reviewed daily by the Nursing Assistants.</p> <p>In-services for all staff will be presented by Director of Nursing on 8-29 and 8-31-11 to re-educate staff on importance of implementing physician orders and keeping care plans accurate. In-services will also address notification of appropriate persons of non-compliance with or refusal of physicians' orders. Also will address importance of reviewing and following care plans daily.</p>	9-1-11

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F 282	<p>Continued From page 10</p> <p>(MDS), dated 07/12/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with ambulation.</p> <p>A review of the Comprehensive Care Plan, dated 06/06/11, revealed staff provided contact guard assistance at all times for ambulation and transfers with a rolling walker. Staff were to store the rolling walker in the shower room, out of the resident's reach.</p> <p>A review of the Daily Nursing Assistant Care Plan, dated 08/11, revealed to keep the rolling walker in the shower room, out of reach.</p> <p>Observations, on 08/03/11 at 8:20 AM and 10:00 AM, 08/04/11 at 8:35 AM, 1:05 PM and 2:00 PM, revealed Resident #9's rolling walker was in the hallway, outside the resident's room.</p> <p>An interview with Certified Nurse Aide (CNA) #7, on 08/04/11 at 1:20 PM, revealed she was not aware of the intervention to store the resident's rolling walker in the shower room. CNA #7 revealed she tried to look at the care plans as often as she could, but stated "we do not have the time we need to check them."</p> <p>An interview with Registered Nurse (RN) #1, on 08/04/11 at 1:30 PM, revealed she reviewed the residents' care plans as needed. RN #1 revealed she was not aware the care plan for Resident #9 specified to store the rolling walker in the shower room.</p> <p>An interview with the Director of Nursing (DON), on 08/04/11 at 2:30 PM, revealed she expected the CNAs to check each resident's care plan</p>	F 282	<p>Charge Nurse will review three care plans per shift three times per week for two weeks, then weekly for one month to ensure care plans are reflective of physician orders and are being followed. Charge Nurse will interview assigned staff to ensure the resident is compliant with orders. Physicians will be notified of resident non-compliance when noted, so appropriate action can be taken. These audits will then be included in the facility Quality Assurance program no less than quarterly.</p>	9-1-11

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F 282	<p>Continued From page 11</p> <p>daily. She revealed staff should store the resident's rolling walker in the shower room, according to the care plan.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 07/17/09 with diagnoses to include Atrial Fibrillation, Dementia and History of Cerebral Vascular Accident/Transient Ischemic Attack.</p> <p>A review of the Comprehensive Care Plan, dated 07/30/09, revealed "Potential for Pressure Ulcers related to decreased mobility, frequent incontinent bladder, incontinence of bowel, use of lap tray to wheelchair, and history of UTI's" with interventions to include "thigh high compression hose on in the AM and off every HS."</p> <p>A review of Resident #4's quarterly Minimum Data Set (MDS), dated 06/24/11, revealed the facility identified Resident #4 to be severely cognitively impaired and required assistance for all activities of daily living.</p> <p>A review of the physician's orders, dated 08/11, revealed an order for "thigh high TED hose- on in the AM, off at HS."</p> <p>A review of the Daily Nursing Assistant Care Plan, dated 08/11, revealed "thigh high TED hose- on in the AM and off every HS."</p> <p>Observations on 08/03/11 at 7:46 AM, 9:20 AM, 10:10 AM, 11:25 AM, and 3:05 PM, and on 08/04/11 at 8:20 AM, revealed Resident #4 did not have TED hose in place.</p> <p>Interviews with Certified Nurse Aides (CNAs) #7,</p>	F 282		9-1-11

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F 282	Continued From page 12 #2, #3, #8 and #9, on 08/04/11 at 9:13 AM, 9:27 AM, 9:43 AM, 11:20 AM, and 11:30 AM, respectively, revealed they referenced the CNA care plans when care was provided and signed the care plans each shift to indicate provision of resident care. CNAs #2, #3, #7, and #9 revealed they were unaware Resident #4 currently utilized TED hose, and CNA #8 stated Resident #4 refused to wear the TED hose. Interviews with Registered Nurse (RN) #1 and RN #2, on 08/04/11 at 10:03 AM and 11:46 AM, respectively, revealed they expected the CNAs to reference the CNA care plans in order to provide care for the residents. An interview with the Director of Nursing (DON), on 08/04/11 at 2:25 PM, revealed CNAs were expected to check the care plans daily, and nurses were to follow up on provision of care to ensure the CNAs followed the care plans.	F 282		9-1-11
F 323 SS=D	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 observations, record reviews and interviews, it was determined the facility failed to	F 323	Medication in resident #11 room was immediately removed. Rolling walker for Resident # 9 is now in the shower room per care plan. Resident #12 did not consume the chicken, the error was noted prior to consumption. All resident rooms were checked on 8-5-11 by Director of Nursing for any medications. All resident care plans were reviewed by Restorative Nurse	9-1-11

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F 323	<p>Continued From page 13</p> <p>ensure the resident's environment remained as free from accident hazards as is possible for three residents (#9, #11 & #12), in the selected sample of 18. Resident #11 was observed on two consecutive days with medication left at the bedside. Additionally, a rolling walker left outside Resident #9's bedroom, and Resident #12 was served a whole piece of chicken instead of ground meat according to his/her diet.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure, undated, revealed "All nurses and nurse aides were required to report to the charge nurse on duty, any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse" and "medications were to be administered by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications."</p> <p>1. A record review revealed Resident #11 was admitted to the facility on 11/15/10 with diagnoses to include Alzheimer's Disease and Senile Dementia.</p> <p>A review of the physician's orders, dated 07/11, revealed "Voltaren 1 % gel, apply 2 grams (gm) to the left knee four times daily (qid)."</p> <p>A review of the instructions, for administration of Voltaren gel, revealed a dosing card with measurements was to be used. The instructions revealed to squeeze Voltaren gel onto the dosing card evenly, up to the 2 gram line and to ensure sure the gel covered the entire 2 gram area of the</p>	F 323	<p>by 8-31-11 to ensure safety interventions are in place and implemented per the resident's plan of care. All tray cards were reviewed by Certified Dietary Manager to ensure diet consistencies were accurate.</p> <p>In-service to be conducted by Director of Nursing on 8-29- & 31-11 to discuss the responsibility of staff to monitor rooms for unauthorized medications as well as review of and implementation of care plans, meal service and checking of meal with diet card at time of meal service.</p> <p>Charge nurse will check resident rooms weekly for one month to ensure compliance related to unauthorized medications at beside. Certified Dietary Manager will check diet cards and tray weekly at point of preparation for four weeks to ensure accuracy. Staff will continue to check tray to diet cards at each meal at time of service. Any</p>	9-1-11

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F 323	<p>Continued From page 14</p> <p>dosing card. The instructions also revealed "Do not apply more than 16 grams of the gel each day to any one affected area.</p> <p>Observations, on 08/02/11 at 11:00 AM, 2:00 PM, 3:00 PM and 4:00 PM, revealed a partially used tube of Voltaren 1 % gel on Resident #11's sink countertop in his/her room.</p> <p>An observation, on 08/03/11 at 8:10 AM, revealed the Voltaren 1 % gel was on the resident's sink counter in a wash basin. At 11:30 AM, the tube of Voltaren 1 % gel was almost empty and observed on the sink counter.</p> <p>An interview with Resident #11, on 08/02/11 at 3:00 PM, revealed he/she rubbed the cream all over his/her arms when he/she itched, but did not know the reason for the medication.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 08/03/11 at 3:10 PM, revealed she was unaware the medication was at Resident #11's bedside and should not be there because this was "an absolute potential for harm," due to wanderers.</p> <p>An interview with the Director of Nursing (DON), on 08/03/11 at 3:30 PM, revealed she was unaware the Voltaren 1 % Gel was left unsupervised at Resident #11's bedside and it should not be left there.</p> <p>2. A review of the policy/procedure "Falls Management," dated 01/01/10, revealed "the facility implemented and monitored interventions to reduce risk factors which placed a resident at risk for falls."</p>	F 323	<p>discrepancies will be corrected prior to consumption. Certified Dietary Manager will keep a list of any discrepancies noted monthly and will provide ongoing education to ensure compliance.</p>	9-1-11

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F 323	<p>Continued From page 15</p> <p>A record review revealed Resident #9 was admitted to the facility on 02/27/06 with diagnoses to include a Fractured Femur, Osteoarthritis and Joint Pain.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 07/12/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with ambulation.</p> <p>A review of the nurses' notes, dated 06/05/11, revealed Resident #9 sustained a fall. The resident was found on the bathroom floor with his/her rolling walker.</p> <p>A review of the Comprehensive Care Plan, dated 05/05/11, revealed staff provided contact guard assistance at all times for ambulation and transfers with the rolling walker. Staff were to keep the rolling walker in the shower room, out of the resident's reach.</p> <p>A review of the Daily Nursing Assistant Care Plan, dated 08/2011, revealed to keep the rolling walker in the shower room, out of the resident's reach.</p> <p>Observations, on 08/03/11 at 8:20 AM and 10:00 AM, 08/04/11 at 8:35 AM, 1:05 PM and 2:00 PM, revealed Resident #9's rolling walker was left in the hallway, outside the resident's room.</p> <p>An interview with Certified Nurse Aide (CNA) #7, on 08/04/11 at 1:20 PM, revealed she was not aware of the intervention to store the resident's rolling walker in the shower room. CNA #7 revealed she looked at the care plans as often as she could, but stated "We do not have the time</p>	F 323		9-1-11	

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F 323	<p>Continued From page 16 we need to check them."</p> <p>An interview with CNA #3, on 08/04/11 at 1:15 PM, revealed the resident's rolling walker was kept in the shower room, but the staff had trouble locating the walker when it was needed. She revealed staff left the walker outside the resident's room.</p> <p>An interview with Registered Nurse (RN) #1, on 08/04/11 at 1:30 PM, revealed she reviewed the resident's care plans as needed. RN #1 revealed she was not aware Resident #9's care plan specified to store the rolling walker in the shower room.</p> <p>An interview with the Director of Nursing (DON), on 08/04/11 at 2:30 PM, revealed therapy had added the intervention to keep the resident's rolling walker out of reach. She revealed if the resident was able to go outside the room and get the walker, it needed to be stored in a different place. The DON revealed she expected staff to store the walker in the shower room, per the care plan.</p> <p>3. A record review revealed Resident #12 was admitted to the facility on 10/09/09 with a diagnosis of Dysphagia.</p> <p>A review of the annual Minimum Data Set (MDS), dated 06/20/11, revealed the facility identified the resident to be severely cognitively impaired and required set up help and supervision while eating.</p> <p>A review of the physician's orders, dated 08/11, revealed an order for a mechanical soft diet with ground meats.</p>	F 323		9-1-11	

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F 323	Continued From page 17 An observation in the dining room, on 08/02/11 at 12:15 PM, revealed Resident #12 was served a whole boneless chicken breast on his/her lunch tray. The resident's diet card specified mechanical soft diet with ground meat. At 12:20 PM, Certified Nurse Aide (CNA) #6 cut the resident's chicken into small pieces. CNA #6 removed the chicken from the resident's lunch tray after surveyor intervention. An interview with CNA #6, on 08/02/11 at 12:25 PM, revealed the resident's lunch tray should have matched the diet card prior to serving the food. An interview with the Dietary Manager, on 08/04/11 at 1:35 PM, revealed Resident #12 received the wrong meat due to an "oversight" on the tray line. An interview with the Director of Nursing (DON), on 08/04/11 at 2:30 PM, revealed she expected nursing staff to compare a resident's tray with the diet card before serving the tray.	F 323		9-1-11	
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	F 441	Nurse #4 was re-educated on 8-25-11 by Registered Nurse on proper hand washing and gloving procedures. Certified Nursing Assistant #1 was re-educated on 8-4-11 by Director of Nursing on handling of soiled linens and use of gloves.	9-1-11	

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F 441	Continued From page 18 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 observations, record reviews, review of facility policy/procedure and interviews, it was determined the facility failed to ensure staff members washed and gloved their hands before and after each provision of direct resident care for two residents (#3 and #8), in the selected sample of 18. Staff members assisted with two skin assessments and did not wash their hands or put	F 441	All residents have the potential to be affected, so Director of Nursing and MDS Coordinator completed chart audits on 8-25-11 of all residents to ensure there were no noted infections over the past 30 days that were related to infection control practices. In-service to be conducted on 8-29 & 31, 2011 to address infection control procedures, emphasizing use of gloves and handling of soiled linens. Director of Nursing will observe skin assessments two times weekly until all nurses have been observed conducting a skin assessment at least once. The Charge Nurse will observe handling of soiled linens on each hall daily for one week, then two times weekly for one week, then weekly for one month. Any issues will be addressed with the individual when noted. These reviews will then be a part of the facility Quality Assurance program.	9-1-11

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F 441	<p>Continued From page 19</p> <p>gloves on, before, during or after the skin assessments. In addition, an ungloved staff member was observed to be holding soiled bed linens while exiting a resident's room, carrying the linens which were not contained in a soiled linen bag, down the hall to the shower room.</p> <p>The findings include:</p> <p>A review of the policy and procedure for "Hand Hygiene," undated, revealed "the staff members were supposed to wash their hands before and after direct or indirect resident contact."</p> <p>1. Observations, on 08/03/11 at 8:28 AM and 8:38 AM, revealed Licensed Practical Nurse (LPN) #4 completed skin assessments for Resident #3 and Resident #8, respectively, without washing her hands or donning any gloves prior to the start of each assessment, or before she left each room. The LPN left each room after touching each resident behind his/her ears, on his/her feet/heels and on his/her hip areas. After she left Resident #8's room, she went to the locked medication room and returned the pulse oximeter machine she took into both residents' rooms. She placed the oxygen measuring device in the medication room. She came back out on the hallway and touched a resident's meal tray, without washing her hands.</p> <p>An interview with LPN #4, on 08/03/11 at 8:45 AM, revealed she was nervous and "just forgot."</p> <p>An interview with the Director of Nursing (DON), on 08/04/11 at 2:48 PM, revealed she expected the staff to wash their hands, don gloves and explain the procedure prior to initiating a skin</p>	F 441		9-1-11

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F 441	<p>Continued From page 20</p> <p>assessment with any resident. She stated the staff have been inserviced on this many times.</p> <p>2. An observation, on 08/04/11 at 10:20 AM, revealed Certified Nurse Aide (CNA) #1 exited a resident's room with both arms around a large bundle of soiled bed linens without any gloves on. Additionally, the soiled linens were not contained in a soiled linen bag. The CNA carried the soiled linen from the resident's room, down the hall to the resident's shower room, and deposited the soiled linen in a large barrel for soiled linen.</p> <p>An interview with CNA #1, on 08/04/11 at 10:23 AM, revealed she should have gloves on and did not. The CNA stated she should put the urine soaked linen in a bag before she carried it down the hall, but she did not have a bag with her when she stripped the resident's bed. The linen barrels were moved outside a resident's room to ensure appropriate containment of soiled linens.</p> <p>Interviews with CNA #2 and CNA #3, on 08/04/11 at 11:25 AM, revealed the soiled linen barrel was to be moved outside the door of the resident that was to have the linens changed. If a situation required transporting soiled linens, they contained them in a linen bag before transporting them and wore gloves.</p> <p>An interview with the Director of Nursing (DON), on 08/04/11 at 11:30 AM, revealed she expected the CNAs to use what they learned in the CNA training. She expected the staff to wear gloves when transporting soiled linen and to keep the soiled linen contained. The DON stated there was no policy and procedure related to transporting soiled linen through resident hall</p>	F 441		9-1-11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 21 areas.	F 441		9-1-11	

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1966, 1978 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One (1) story Type II ooo in the (1968 section). One (1) story Type V ooo located in the (1978 edition). Smoke Compartment: Three (3) smoke compartments Fire Alarm: Complete fire alarm with heat detectors located in rooms of the (1968 section) and smoke detectors located in corridor of the (1978 section). Manual pull stations located at exits. Sprinkler System: Complete automatic (dry) sprinkler system. Generator: Type II diesel generator installed in 2007. A standard Life Safety Code survey was conducted on 08/04/2011. Professional Care Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was eighty six (86). The facility is licensed for one hundred and ten (110) residents. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire)	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	K 048	No residents affected. All staff will be in-serviced to location of existing fire and smoke compartments on 8-31-11.	9-1-11



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

TITLE

(X6) DATE

Patricia A. Donald, Administrator

P-11

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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K 048	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire safety plan addressed the needs of the facility according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred and ten (110) residents, staff and visitors. The census the day of the survey was eighty six (86).</p> <p>The findings include:</p> <p>Interview on 08/04/2011 at 10:00 AM, with the Maintenance Director, revealed the facility trains staff to relocate residents during a fire past the double doors located in the hallways. The facility contained seven (7) sets of double located throughout the facility.</p> <p>Observation on 08/04/2011 at 10:20 AM, with the Maintenance Director, revealed the facility has three (3) smoke compartments. Smoke/fire barriers can be found in the East Hall located near the common area/sports room and next to the Lobby. Smoke/fire barriers can be found in the West hall located near the Ambulance Entrance and the Lobby. This was a total of four (4) sets of double doors. The other three (3) sets of double doors did not meet the requirements for a smoke barrier but was being used by the facility as smoke barrier doors.</p> <p>Interview on 08/04/2011 at 10:23 AM, with an LPN, revealed the facility had trained her to move to residents during a fire past the double doors located in the facility.</p>	K 048	<p>At completion of in-service a five question and answer test will be administered. Maintenance will utilize a diagram of fire and smoke compartments monthly when conducting fire drills as a visual tool for employees for ongoing in-servicing.</p> <p>In addition, all Fire and Disaster booklets located at designated areas throughout facility will be updated complete with pictures. The Fire and Disaster booklet will be used in orientation of new employees and continued education for all employees.</p> <p>All residents no longer have potential to be affected since corrected.</p> <p>Monitoring will be done when fire drills conducted monthly and documented in preventative maintenance booklet.</p>	9-1-11	

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K 048	Continued From page 2 Reference: NFPA 101 (2000 edition) 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception:* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients	K 048		9-1-11	

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K 048	Continued From page 3 as detailed in the health care occupancy 's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire	K 048		9-1-11	