

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED JUN 18 2012 05/17/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 40122 Southern Intergroup Branch
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F 000	INITIAL COMMENTS	F 000	F # 157	
F 157 SS=D	<p>A standard health survey was conducted on 05/15-17/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</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>	F 157	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <p>1. Resident # 7 had a new weight obtained. The physician and responsible party were notified of resident # 7's weight gain.</p> <p>Please note that resident had refused to be weighed. Resident's weight was obtained on 5/17/12 and it was the same as the prior weight recorded. Staff attempted to weigh resident each week with refusals documented each time. Resident stated that the reason she did not want to be weighed was due to her own knowledge that she had gained weight. The Director of Nursing referred this information to the Registered Dietician who has set up a diet regimen to assist the resident</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Linda Stidham RN</i>	TITLE DON	(X6) DATE 06-15-12
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to notify the physician when a significant change in condition occurred for one of twenty sampled residents (Resident #7). Resident #7 experienced a weight gain of twenty-three pounds over eight months but there was no evidence the facility notified the resident's physician of this significant weight gain.</p> <p>The findings include:</p> <p>A review of the "Changes in Resident's Condition or Status" policy, no date given, revealed the physician was to be notified when there was a significant change in the resident's physical, mental, or emotional status and/or if there was a need to alter the resident's treatment or medications. The policy further indicated the physician was to be notified if the resident refused treatment/medications and the reasons why.</p> <p>A review of the medical record for Resident #7 revealed the facility admitted the resident on 02/10/09, with diagnoses that included Cerebrovascular Accident, Bi-Polar Disorder, Seizure Disorder, Depression, Anxiety, Status Post Colectomy with Colostomy, and Senile Dementia.</p> <p>A review of the Nutritional Progress Notes, dated 03/13/12, revealed Resident #7's current weight was 185 pounds, an increase of 14.2 percent in 240 days. There was no indication in the</p>	F 157	<p>with a planned weight loss. Resident is adherent to this diet regimen and pleased with the results.</p> <ol style="list-style-type: none"> Any resident refusing treatment or having a change in condition had the potential to be affected. <p>A 100% audit has been conducted by the Nursing Management Team of all active residents' records to ensure that any refusals or change in condition had physician and responsible parties notified with revisions made to the care plan and orders as indicated.</p> <ol style="list-style-type: none"> Charge nurses will utilize the 24-hour shift report to document any refusals or change in condition by resident. The Director of Nursing/Nursing Management Team will review the 24-hour shift reports Monday through Friday to ensure that the physician and responsible party have been notified of any refusals or change in condition. <p>The SDC inserviced all licensed nurses on May 24, 2012 and May 25, 2012 regarding physician notification, notification of responsible parties, and documenting refusals and change in condition on the 24-hour shift reports. Licensed nurses will be inserviced on change in condition with physician notification upon hire, annually, and as needed.</p>		

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F 157	<p>Continued From page 2</p> <p>physician's progress note that facility staff had notified the physician of the resident's significant weight gain.</p> <p>A review of the Care Plan Conference Record, dated 04/03/12, revealed the care plan team reviewed the resident's weight and diet but there was no indication the care plan team had notified the resident's physician of the resident's unplanned weight gain.</p> <p>An interview with the Minimum Data Set (MDS) nurse on 05/16/12, at 2:55 PM, revealed Resident #7 often refused care and that staff should have notified the physician when the resident refused to allow staff to weigh him/her and when the weight gain occurred.</p> <p>An interview with the Unit Manager (UM) on 05/17/12, at 9:15 AM, revealed she notified the physician of the resident's weight gain and the physician indicated the weight gain was due to edema and ordered staff to elevate the resident's legs. However, a review of documentation revealed staff failed to document the physician's notification and/or orders. The UM further stated the resident often refused to allow staff to weigh her/him, but there was no documentation to indicate the physician had been made aware of the resident's refusals.</p> <p>An interview with the Dietary Manager (DM) on 05/16/12, at 4:10 PM, revealed the DM was unable to remember if she had notified the facility's Registered Dietitian (RD) of Resident #7's weight gain. The DM stated, "I should have, but I don't remember doing it." The DM further stated the resident had often refused to allow</p>	F 157	<p>4. The Director of Nursing/Nursing Management Team will perform audits of all refusals and changes in condition to ensure notification of physician and responsible parties. These audits will be conducted daily Monday-Friday x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance- June 25, 2012.</p>		

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F 157	Continued From page 3 staff to obtain the resident's weight. An interview with the RD on 5/17/12, at 12:10 PM, revealed she had not been made aware of Resident #7's weight that was obtained on 02/17/12 until 04/26/12. The RD stated before making a recommendation to the resident's physician, she had requested for staff to reweigh Resident #7 since the most recent weight was over two months old, but she had not been notified that the resident had been reweighed and, as a result, had not notified the physician of the resident's weight gain.	F 157	F # 242 1. A tray with resident's likes was made available for resident # 17 when she awoke and Dietary Manager updated preference list on 5/17/12. 2. No other resident's were affected. A 100% review will be completed per the Dietary Manager by 6/8/12 to ensure that all tray cards are updated with resident dislikes.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure food preferences were honored for one of twenty sampled residents (Resident #17). Although facility staff had assessed/identified Resident #17's food dislikes, observation of a meal service on 05/17/12, revealed facility staff served Resident #17 several foods identified as foods the resident disliked.	F 242	3. All nursing and dietary staff were inserviced by the SDC and Dietary manager on 5/24/12, 5/25/12, and 6/7/12 regarding checking tray cards to ensure that no dislikes are offered during meals. One dietary aide will be placed at the end of the tray line to ensure that specified dislikes are not placed on food trays prior to being placed on food cart. 4. The Dietary Manager and/or RD will audit one meal daily x 30 days, weekly x 4 weeks, monthly x 2 months, and randomly to ensure no dislike are offered during meals. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5. Date of Compliance – June 25, 2012.	

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F 242	<p>Continued From page 4</p> <p>The findings include:</p> <p>A review of facility policy, revised 07/23/09, revealed the facility would conduct a Nutrition Data Collection/Assessment at admission, annually, and when a comprehensive Minimum Data Set assessment was completed. According to the policy, personal and cultural food preferences would be obtained, along with snack patterns and dislikes.</p> <p>A review of the medical record revealed the facility admitted Resident #17 on 11/23/11, with diagnoses that included Dementia with Behaviors, Depression, Hypertension, and Dysphagia.</p> <p>According to the nutritional progress note, dated 11/23/11, Resident #17 was alert and able to communicate dietary needs. A review of the resident's dietary preference card revealed some of the foods Resident #17 indicated he/she disliked were pasta, carrots, and broccoli. In addition, the card contained a special request for extra gravy and margarine.</p> <p>Observations of the lunch meal on 05/17/12, at 12:30 PM, revealed Resident #17 was served dry, chopped chicken over pasta, mashed potatoes, and mixed vegetables which contained carrots and broccoli. Observation of the meal revealed staff had failed to provide margarine and/or gravy/sauce as requested by Resident #17 with the resident's meal.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 05/17/12, at 12:30 PM, revealed Resident #17 had displayed violent/combative behaviors</p>	F 242		

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F 242	Continued From page 5 earlier in the day, was sleeping, and therefore, an interview was not attempted with Resident #17.	F 242	<u>F # 248</u> 1. The television in resident # 6's room was immediately turned on with resident's permission. Please note that resident had gotten up on 5/17/12 for out of room activities.	
F 248 SS=D	An interview with the Dietary Manager (DM) at 1:15 PM on 5/17/12, revealed the DM was aware of Resident #17's preferences. The DM stated there was a kitchen staff person stationed at the end of the serving line to check for accuracy of residents' meal trays. According to the DM, the kitchen staff had "just missed it." 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined the facility failed to ensure an ongoing program of activities designed to meet the interests and physical, mental, and psychosocial well-being was provided for one of twenty sampled residents (Resident #6). Resident #6 was observed in the room on 05/15/12 and 05/16/12, with no lights on and the privacy curtain blocking the resident's view of the hallway. The findings include: Review of the facility policy/procedure, Components of a Therapeutic Recreation Program (dated as revised 03/15/07), revealed	F 248	2. The Director of Activities and Assistant conducted room visits on 5/16/12 to ensure that all residents were receiving activities. No other resident was affected. The Director of Activities/Designee conducted a 100% audit on 6/4/12 to determine if all resident's were receiving activities whether in or out of their room and if resident's continue to desire/require in room activities that are resident specific and care planned. 3. On 6/4/12 the Executive Director inserviced the Activities Department on proper documentation of in and out of room activities on the Individual Resident Daily Participation Record; that has been updated to reflect in and out of room activities, and no ensure that all residents are receiving activities whether in or out of their room. All nursing staff was inserviced on 5/24/12 and 5/25/12 regarding residents being offered activities whether in or out of their room.	

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F 248	<p>Continued From page 6</p> <p>Therapeutic Recreation Services were intended to provide each resident an opportunity to maintain a leisure lifestyle to the extent possible and to improve or maintain each resident's physical, mental, and psychosocial well-being. The procedure for responsibilities revealed recreation treatment services would be designed to enable residents with physical, mental, emotional, and/or social needs to improve their functioning level and/or affect behavioral changes....be relevant to the individual and his or her goals.</p> <p>Observations of Resident #6 on 05/15/12, at 3:04 PM, 4:24 PM, and 4:57 PM, and on 05/16/12, at 9:38 AM, 10:23 AM, 11:03 AM, 1:21 PM, and 2:10 PM, revealed during each observation the resident was in bed with the room darkened. No music or television was observed in the room and the resident's privacy curtain was partially blocking the resident's view of the hallway. Attempts at conversation with Resident #6 were unsuccessful. The resident's speech was garbled and responses were unintelligible.</p> <p>Review of the medical record of Resident #6 revealed the facility admitted the resident on 09/04/06, with diagnoses that included Dysphagia, Huntington's Chorea, Depressive Disorder, Psychosis, Episodic Mood Disorder, and Generalized Pain. Review of the annual comprehensive assessment completed for Resident #6 on 08/26/11, revealed the resident was moderately cognitively impaired and had short-term and long-term memory problems. Additionally, the resident was assessed to have unclear speech, rarely/never makes self understood, and sometimes understands others.</p>	F 248	<p>4. With Executive Director oversight, the Director of Activities/Assistant will conduct audits to ensure that all residents are receiving activities whether in or out of their room. These audits will be conducted daily x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance- June 25, 2012.</p>	
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F 248	<p>Continued From page 7</p> <p>The resident was also assessed to have inattention and disorganized thinking. Further review of the comprehensive assessment revealed the resident could not be interviewed for activity preferences and had been assessed by staff to prefer bed baths, staying up, family/friends involved in care, and music. The resident was assessed to require extensive assistance of staff for all activities of daily living.</p> <p>Review of the comprehensive care plan for Resident #6 dated 08/17/11, revealed an identified problem area of little to no involvement in activities due to cognitive impairment. The interventions listed for Resident #6 included the following:</p> <ul style="list-style-type: none"> -Offer opportunities for success and praise as often as possible -Engage resident in group activities -Arrange one-to-one contacts with resident -Schedule activities to allow for limited energy -Respect resident desire to be alone on occasion -Give resident verbal reminders of activity before commencement of activity -Offer reality orientation on all possible occasions and contacts. <p>Review of the Individual Resident Daily Participation Record for Resident #6 dated March 2012 revealed the resident received in-room visits eight times that month and was documented as refusing television and music. Documentation of activities for April 2012 revealed the resident received in-room visits on seven occasions that month and was documented as refusing television and music and was unable to attend bingo. Review of the activities documentation</p>	F 248		

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F 248	Continued From page 8 dated May 2012 revealed the resident was documented as an active participant on 05/09/12, in a sing-a-long and religious services. The participation record listed numerous activities; however, there was no documentation to indicate the resident had attended/participated in any out-of-room activities. Interview with the Activities Director on 05/16/12, at 3:30 PM, revealed the Activities Director was responsible for the development of the activity care plan for the residents in the facility. According to the Activities Director, when Resident #6 was up the resident would attend singing activities and if the resident was not up activity staff would conduct in-room visits. The Activities Director stated the resident refused the television and music at times. The Activities Director confirmed the resident's speech was poor but the resident did answer staff questions. The Activities Director was unsure if the resident understood what was said to her. Interview with Certified Nursing Assistant (CNA) #11 on 05/16/12, at 2:20 PM, revealed the CNA was responsible for the care of Resident #6. The CNA stated the resident received restorative activities from the restorative aide. According to CNA #6, the resident was not provided activities. Interview with CNA #12 on 05/16/12, at 2:30 PM, revealed the CNA had worked with Resident #6 for approximately the last eight days and had not observed any activities provided to the resident.	F 248			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 9</p> <p>Incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and a review of facility policy the facility failed to revise/update the plan of care for two of twenty sampled residents (Residents #7 and #11). Resident #7 was noncompliant with wearing anti-embolism hose (TED hose) and allowing staff to obtain the resident's weight. Resident #11's oxygen was to be maintained at two liters/minute but the oxygen was either turned off, or at three liters/minute or at four liters/minute. There was no evidence the facility revised/updated the plans of care for these residents to address their noncompliance.</p> <p>The findings include:</p>	F 280	<p>F # 280</p> <p>1. The physician and responsible party were notified of resident # 7 having refused to be weighed. Resident was weighed on 5/17/12 and a referral was made to the Registered Dietician in regards to residents statement that she "wants to lose weight". The RD is assisting resident with a planned weight loss and resident is currently adherent to the diet regimen. The physician and responsible party were also notified that resident # 7 refuses to wear TED hose and new orders were received per physician to discontinue TED hose.</p> <p>The physician and responsible party were notified of resident # 11 having titrated her own oxygen flow rate with no new orders received. Resident was educated regarding benefits/consequences of adherence to physician orders.</p> <p>A lock-key device was installed on resident # 11's oxygen concentrator to prevent resident from adjusting oxygen flow rate. The SDC inserviced all nurisng staff on 6/6/12 in regards to proper use of this lock-key device.</p> <p>2. A 100% audit of all care plans was completed on 6/8/12 to ensure care plans are followed as written and residents are adherent with</p>	

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F 280	<p>Continued From page 10</p> <p>A review of the facility's care plan policy, no date listed, revealed the facility would develop an individualized, interdisciplinary care plan and this care plan was to be reviewed at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services. According to the policy, review and evaluation were to include progress made and goals continued, no progress and a change of approach, or may show accomplishment of a short-term goal and a new goal and approach, and causative factor.</p> <p>1. A review of the medical record for Resident #7 revealed the facility admitted the resident on 02/10/09, with diagnoses that included Cerebrovascular Accident, Bi-Polar Disorder, Seizure Disorder, Depression, Anxiety, Status Post Colectomy with Colostomy, and Senile Dementia. A review of the comprehensive care plan, dated 12/23/11 and reviewed by the facility on 3/13/12, revealed approaches to meet the resident's goals included: monitor weight monthly or as needed and monitor meal intake records as needed. Further review of the plan of care for Resident #7 revealed the resident was to wear TED hose during the day and they were to be applied at 6:00 AM. In addition, according to the care plan the hose were to be removed at bedtime.</p> <p>Observations of Resident #7 on 05/15/12, 05/16/12, and 05/17/12, revealed no TED hose were in use for this resident.</p> <p>An interview with State Registered Nurse Aide (SRNA) #13 on 05/16/12, at 2:30 PM, revealed</p>	F 280	<p>prescribed regimen. The physician and responsible party were notified of any nonadherence identified with care plan revisions made as indicated.</p> <p>3. All nursing staff was inserviced on 5/24/12 and 5/25/12 regarding revision of care plans. Nursing staff will place any change in condition on the 24-hour shift report and revise care plans as indicated. The Nursing Management Team will review the 24-hour reports and care plans daily Monday-Friday to ensure proper documentation, notification of physician and responsible party, and care plan revisions has occurred.</p> <p>4. The DON/CCC will conduct audits of 24-hour shift report to ensure that any change in condition has care plans revised as indicated. These audits will be conducted daily (Monday-Friday) x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance- June 25, 2012.</p>	

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F 280	<p>Continued From page 11</p> <p>Resident #7 would not allow staff to apply the TED hose. According to the SRNA, the resident "just won't wear them." SRNA #13 further stated the resident would not allow staff to obtain the resident's weight.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 05/16/12, at 2:35 PM, revealed Resident #7 had brought the TED hose to the nurses' desk a few days prior to the interview. LPN #2 stated she got busy and distracted and forgot to follow up on why the resident refused to wear the TED hose and thought another nurse had addressed the problem. LPN #2 further stated she was aware the resident refused to allow staff to weigh her/him.</p> <p>An interview with the Minimum Data Set (MDS) nurse on 05/16/12, at 2:55 PM, revealed the she was aware of the resident's noncompliance with wearing the TED hose and refusing to be weighed and believed a care plan to address these issues had been developed. However, the MDS nurse was unable to provide a care plan to address Resident #7's noncompliance with the care plan interventions.</p> <p>2. Observation of Resident #11 on 05/15/12, at 2:55 PM, 4:30 PM, and 6:00 PM; and on 05/16/12, at 9:05 AM, 10:00 AM, 11:05 AM, and 1:15 PM, revealed the resident was not wearing his/her oxygen. Observation on 05/16/12, at 2:00 PM, revealed the resident was being administered oxygen at 3 liters per minute by nasal cannula. Observation on 05/17/12, at 6:15 AM, revealed the resident was being administered oxygen at 4 liters per minute by nasal cannula.</p>	F 280		
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F 280	<p>Continued From page 12</p> <p>A review of the medical record for Resident #11 revealed the resident was admitted by the facility on 07/09/10, with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Hypertension.</p> <p>A review of the roster sample matrix completed by the facility on 05/15/12, revealed the facility had assessed Resident #11 to be cognitively impaired and not interviewable.</p> <p>A review of the physician's orders for Resident #11 revealed a physician's order dated 05/01/12, for oxygen to be administered to the resident at 2 liters per minute by nasal cannula.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 on 05/17/12, at 6:15 AM, revealed she was responsible for the care of Resident #11 on 05/17/12, on the 7:00 PM-7:00 AM shift (night shift). The LPN stated she was aware of the physician's order for Resident #11 to receive oxygen at 2 liters per minute by nasal cannula, however, the LPN revealed the resident would oftentimes remove his/her oxygen or change the oxygen settings. The LPN stated facility staff should have developed a care plan intervention regarding the resident's noncompliance to wear his/her oxygen at the physician's ordered settings, and acknowledged staff had failed to develop the interventions.</p> <p>An interview conducted with LPN #4 on 05/17/12, at 8:00 AM, revealed the LPN had been responsible for Resident #11's care and to ensure the resident received oxygen at the prescribed rate on 05/15/12 and 05/16/12, on the (7:00 AM-</p>	F 280		

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F 280	Continued From page 13 7:00 PM) day shift. The LPN also stated Resident #11 was noncompliant with wearing his/her oxygen as it was ordered by the physician and stated the resident would take off the oxygen or would change the settings. The LPN revealed she was responsible for making care plan changes whenever changes occurred and added staff should have developed a care plan intervention related to the resident's noncompliance with oxygen therapy. An interview conducted on 05/17/12, at 7:25 AM, with the Minimum Data Set (MDS) nurse revealed the she was aware of Resident #11's noncompliance with his/her oxygen therapy and stated there should have been a care plan to address the resident's noncompliance, however, the MDS nurse stated the facility had failed to develop the care plan. An interview conducted with the Director of Nursing (DON) on 05/17/12, at 2:50 PM, revealed nurses were required to update the care plan as needed, and staff should have developed a care plan to address the resident's noncompliance with oxygen therapy. The DON stated any nurse responsible for the care of a resident could add or change a care plan intervention if changes occur with a resident.	F 280			
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:	F 281			

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F 281	<p>Continued From page 14</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed by staff for two of twenty sampled residents (Residents #7 and #1). Resident #7 had physician's orders for anti-embolic (TED) hose to be worn daily, however, observations revealed facility staff failed to ensure Resident #7 wore the TED hose as prescribed by the physician. In addition, Resident #7's physician had requested a chair alarm be used for Resident #7 at all times, however, observations revealed facility staff failed to ensure an alarm was utilized for Resident #7 as requested by the physician. Continued review of physician's orders revealed Resident #1's physician had requested a "scoop" mattress be utilized for Resident #1 but observations revealed staff failed to ensure a scoop mattress was utilized for the resident.</p> <p>The findings include:</p> <ol style="list-style-type: none"> A review of the medical record for Resident #7 revealed the facility admitted the resident on 02/10/09, with diagnoses that included Cerebrovascular Accident, Bi-Polar Disorder, Seizure Disorder, Depression, Anxiety, Status Post Colectomy with Colostomy, and Senile Dementia. <p>A review of physician's orders dated 05/01/12, revealed the physician had ordered for Resident #7 to have TED hose applied at 6:00 AM, and removed at bedtime daily. In addition, the physician ordered a chair alarm at all times for Resident #7.</p> <p>Observations conducted on 05/15/12, 05/16/12,</p>	F 281	<p>F # 281</p> <ol style="list-style-type: none"> The physician and responsible party were notified of resident # 7's nonadherence in regards to wearing physician prescribed TED hose and chair alarm. New orders were received per physician at that time to discontinue the use of TED hose and continue use of chair pad alarm. Resident was re-educated regarding benefits/consequences of using chair alarm per physician orders. Resident verbalized understanding and allowed staff to replace the chair pad alarm in her wheelchair at that time. A scoop mattress was placed on resident # 1 bed, the physician and responsible party were notified. A 100% audit was completed on 6/6/12 by the Nursing Management Team to ensure that care plans and care guides reflected physician orders and ordered devices were in place. Any issues identified will have physician and responsible party notified and care plans revised as indicated. 	

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F 281	<p>Continued From page 15 and 05/17/12, revealed facility staff failed to ensure TED hose were in use for Resident #7. In addition, observations on 05/15/12 and 05/16/12, revealed no evidence of a chair alarm in use for Resident #7.</p> <p>An interview with State Registered Nurse Aide (SRNA) #13 on 05/16/12, at 1:30 PM and 2:30 PM, revealed Resident #7 would not allow staff to apply the TED hose; according to the SRNA, the resident "just won't wear them." SRNA #13 further stated she provided care for Resident #7 on 05/16/12, and noticed an alarm was not in place to the resident's chair and assumed it had been discontinued. SRNA #13 stated she intended to ask the nurse but forgot to do so.</p> <p>An interview with the Charge Nurse, Licensed Practical Nurse (LPN) #2 on 05/16/12, at 1:35 PM and 2:35 PM, revealed Resident #7 brought the TED hose to the nurses' desk a few days prior to the interview because the resident had refused to wear the hose. LPN #2 stated she got busy and distracted and forgot to follow up on the TED hose and assumed another nurse had addressed the problem. LPN #2 further stated she failed to notice the chair alarm was not on Resident #7's chair as requested by the physician.</p> <p>2. A review of the medical record revealed the facility admitted Resident #1 on 04/26/12, with diagnoses that included Dementia with Behaviors, Psychosis, Congestive Heart Failure, Diabetes, Depression, and Renal Insufficiency. A review of physician's orders, dated 05/01/12, revealed the physician had ordered a scoop mattress for Resident #1's bed.</p>	F 281	<p>3. The SDC inserviced all nursing staff on 5/24/12 and 5/25/12 regarding following care plans, care guides, and ensuring that devices are in place as ordered by physician. Education provided regarding interfacility transfer to ensure when residents are transferred that all ordered devices are transferred with resident and in place as ordered. DON/Unit Managers will review 24 hour report and any MD orders Monday thru Friday for devices or room changes. Care plan and Care Guide will be revised and observation completed to ensure all devices are placed on or transferred with resident per MD order.</p> <p>4. The Unit managers, with Director of Nursing oversight, will audit care guides and care plans to ensure that ordered devices are in place as listed on care guides daily Monday through Friday x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – June 25, 2012.</p>		

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F 281	Continued From page 16 Observations on 5/15/12 and 5/16/12, revealed there was no evidence of a scoop mattress on Resident #1's bed. An interview was conducted with LPN #2 on 05/17/12, at 8:00 AM. LPN #2 stated there should have been a scoop mattress on the bed and she had not noticed that it was not there. An interview with the Unit Manager (UM) on 05/17/12, at 8:00 AM, revealed the UM was unaware the scoop mattress had not been placed on Resident #1's bed.	F 281	Tag # F 315 1. Resident # 3's physician and responsible party were notified that there was no supporting diagnosis for an indwelling catheter that was inserted during recent hospitalization. At that time, the physician gave new orders to begin catheter clamping program and discontinue indwelling catheter after completion. Catheter was discontinued on 5/24/12. 2. A 100% audit was completed on 5/17/12 to ensure that every resident with an indwelling catheter in place had a supporting diagnosis for its use. All residents with foley catheters had a supporting diagnosis. 3. All licensed nurses were inserviced by the SDC on 5/24/12 and 5/25/12 regarding importance of obtaining a diagnosis to support indwelling catheter use.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that the use of an indwelling urinary catheter without a documented medical justification for its use did not occur for one of twenty-three sampled residents (Resident #3). On 04/10/12, Resident #3 was admitted to the facility after an admission to a local acute care hospital and was noted to	F 315			

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F 315	<p>Continued From page 17</p> <p>have an indwelling urinary catheter in place. Observation of Resident #3 on 05/15/12, revealed although the urinary catheter remained in place there was no documented evidence to support the continued use of the indwelling urinary catheter for Resident #3.</p> <p>The findings include:</p> <p>A review of the facility's undated Indwelling Catheter policy revealed a resident that entered the facility without an indwelling urinary (Foley) catheter should not be catheterized unless the person's clinical condition demonstrated that catheterization was necessary. In addition, according to the policy, a resident that entered the facility with a urinary catheter would have the catheter discontinued if there was no medical justification for the use of the catheter.</p> <p>A review of the medical record for Resident #3 revealed the facility discharged the resident on 04/03/12, and readmitted the resident on 04/10/12, with diagnoses that included insulin dependent diabetes mellitus, Methicillin Resistant Staph Aureus, Vancomycin Resistant Enterococcus of the rectum, pacemaker, failure to thrive with gastrostomy tube for nutrition support, and acute respiratory failure. Documentation revealed Resident #3 reentered the facility from the acute care hospital with an indwelling Foley catheter on 04/10/12. A review of a physician's order dated 05/03/12, revealed an order for an indwelling urinary catheter. However, there was no evidence of a diagnosis to support the medical justification of the continued use of the indwelling Foley catheter.</p>	F 315	<p>4. The Director of Nursing will complete Catheter Justification Flow Sheet for all residents requiring a foley catheter to ensure all catheters have a supporting diagnosis.</p> <p>The DON/Unit Managers will audit all admission/readmissions residents and MD orders to ensure that any resident with an indwelling catheter has a supporting diagnosis during the morning meeting. These audits will be conducted daily Monday thru Friday x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – June 25, 2012.</p>		

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F 315	<p>Continued From page 18</p> <p>Observations of Resident #3 on 05/15/12, at 2:40 PM; on 05/16/12, at 9:15 AM; and on 05/16/12, at 11:15 AM, revealed the resident had an indwelling urinary catheter in place. Resident #3 was grasping the catheter tubing in her/his hands and was pulling on the catheter tubing.</p> <p>An interview was conducted with the facility Director of Nursing (DON) on 05/17/12, at 4:15 PM. The DON acknowledged there was no documented diagnosis on the resident's medical record to justify the continued use of the indwelling Foley catheter.</p>	F 315		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility temperature logs it was determined the facility failed to ensure the resident environment was free from hazards as evidenced by the water temperatures in resident rooms being above the maximum safe water temperature of 100-110 degrees Fahrenheit as recommended by state requirements. Four resident rooms (three in Rose Garden and one on Hope Hall) had water temperatures from 112 degrees Fahrenheit to 116</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522		
(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 323	<p>Continued From page 19 degrees Fahrenheit.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure, Water Temperature Inspection, revised 03/15/04, revealed temperatures would be taken each week from one resident's room on each wing on a rotating basis. The policy/procedure revealed a satisfactory temperature was in the range of 100 degrees Fahrenheit (F) to 120 degrees F (safe water temperatures were defined per state regulations as 100-110 degrees F). The policy failed to ensure the water temperatures were within acceptable parameters established by state regulations.</p> <p>Observations on 05/17/12, at 7:44 AM, revealed the water temperature in the sink of resident room 606 was 112 degrees Fahrenheit (F), resident room 602 was 112 degrees F, and resident room 605 was 116 degrees F. At 7:50 AM, the water temperature in resident room 701 was 116 degrees F. Each of the above rooms had at least one resident who could access the water in the sink. Rooms 606, 602, and 605 were located in the locked area of the facility where severely cognitively impaired residents resided.</p> <p>A review was conducted of the water temperature logs maintained by the facility dated 04/26/12, 05/02/12, and 05/10/12. The water temperatures on 04/26/12, ranged from a low of 114.7 degrees F in room 501 to a high of 118.3 degrees F in room 804. The water temperatures on 05/03/12, ranged from a low of 117.9 degrees F in room 201 to a high of 122.2 degree F in room 616. On 05/10/12, the water temperatures ranged from a</p>	F 323	<p><u>F # 323</u></p> <ol style="list-style-type: none"> Maintenance Director adjusted water temperature immediately on 5/17/12 when notified. Facility had been following company water temperature policy that has now been updated to reflect state regulation guidelines. All residents have the potential to be affected. The Executive Director inserviced the Maintenance Director and Assistant on 6/6/12 in regards to state regulations on water temperature to ensure that water is safe for resident use at no greater than 110 degrees fahrenheit. The Maintenance Director/Assistant will assess/document water temperatures twice daily x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly to ensure water temperatures maintain within state regulation guidelines. Executive Director will assess water temperatures randomly daily Monday thru Friday times 30 days. <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <ol style="list-style-type: none"> Date of Compliance – June 25, 2012. 		

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F 323	Continued From page 20 low of 109.2 degrees F in room 201 to a high of 113/4 degrees F in room 204. The facility did not test the water temperatures in any of the rooms in the Rose Garden (600 rooms) or the hallways adjacent to the Rose Garden where the higher water temperatures were found. Interview with the facility Maintenance Director on 05/17/12, at 8:28 AM, revealed the Maintenance Director was unaware of a facility policy/procedure for maintaining safe water temperatures. According to the Maintenance Director, he had been instructed to maintain the water temperatures below 120 degrees F. The Maintenance Director stated some of the water temperatures go up occasionally. The Maintenance Director stated the water temperatures were monitored weekly. Interview with the facility Administrator on 05/17/12, at 8:32 AM, revealed the facility did have a policy/procedure for water temperatures. According to the Administrator, the water temperatures should be below 120 degrees F. Interview with the facility corporate consultant on 05/17/12, at 9:15 AM, revealed safe water temperatures should be between 100-110 degrees F in accordance with state requirements.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328			

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F 328	<p>Continued From page 21</p> <p>Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure one of twenty sampled residents (Resident #11) received proper care and treatment related to oxygen administration. Resident #11 had a physician's order dated 05/01/12, for oxygen to be administered at two liters by nasal cannula, however, observations revealed staff failed to ensure the resident's oxygen was in use and/or that the oxygen was administered at the correct amount.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Oxygen Use, General," undated, revealed oxygen therapy would be administered to the resident upon the written order of a licensed physician.</p> <p>A review of the medical record revealed the facility admitted Resident #11 on 07/09/10, with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Hypertension.</p> <p>A review of the physician's orders for Resident #11 revealed a physician's order dated 05/01/12, for oxygen to be administered at 2 liters by nasal</p>	F 328	<p>F # 328</p> <ol style="list-style-type: none"> 1. Resident # 11's oxygen flow rate was returned to prescribed amount. The physician and responsible party were notified of resident having titrated own oxygen flow rate. Resident was educated regarding benefits/ consequences of adherence to prescribed oxygen flow rate. A lock-key device was installed on 6/6/12 to resident # 11's oxygen concentrator which prevents resident fro adjusting own oxygen flow rate. The SDC inserviced all nursing staff regarding proper use of lock-key device for oxygen concentrator. 2. A 100% audit was conducted to ensure that every resident receiving oxygen had oxygen flow rate set per physician orders. No other residents were found to have been affected. 3. The SDC inserviced all nursing staff on 5/24/12 and 5/25/12 regarding the monitoring of oxygen flow rate settings when providing care. 	
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F 328	<p>Continued From page 22 cannula.</p> <p>Observation of Resident #11 on 05/15/12, at 2:55 PM, 4:30 PM, and 6:00 PM, revealed the resident was not wearing his/her oxygen. Observation on 05/16/12, at 9:05 AM, 10:00 AM, 11:05 AM, and 1:15 PM, revealed the resident was not wearing his/her oxygen. Observation at 2:00 PM, revealed the resident was being administered oxygen at 3 liters by nasal cannula. Observation on 05/17/12, at 6:15 AM, revealed the resident was being administered oxygen at 4 liters by nasal cannula.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 on 05/17/12, at 6:15 AM, revealed the LPN was responsible for the care of Resident #11 on the 7:00 PM-7:00 AM night shift on 05/17/12. The LPN stated she made rounds several times during her shift to ensure the residents were getting the care they required. The LPN stated she was aware Resident #11 was to be administered oxygen at 2 liters by nasal cannula, however, the LPN revealed the resident would oftentimes take the oxygen off or change the settings. The LPN acknowledged she failed to notify the resident's physician of the resident's noncompliance with the oxygen use.</p> <p>An interview conducted with LPN #4 on 05/17/12, at 8:00 AM, revealed the LPN had been responsible to ensure the oxygen was delivered in accordance with physician's orders for Resident #11 on 05/15/12 and 05/16/12, from 7:00 AM-7:00 PM. The LPN stated she made observations several times a day to ensure residents were getting the care they required, and stated Resident #11 takes off his/her oxygen</p>	F 328	<p>4. Charge Nurses will assess oxygen concentrators when providing care to ensure that proper settings are in place per physician orders and that lock-key devices are in use for prescribed residents. The charge nurse will record oxygen flow rate setting every shift on Treatment Administration Record ongoing.</p> <p>The Unit managers, with Director of Nursing oversight, will conduct audits to ensure that oxygen concentrators are set to prescribed settings and that lock-key device is in use. These audits will be conducted daily Monday – Friday x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated.</p> <p>5. Date of Compliance – June 25, 2012.</p>	

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F 328	Continued From page 23 himself/herself. The LPN also stated the resident has also changed the oxygen settings himself/herself. The LPN stated she had not informed the physician of Resident #11's noncompliance with the use of the oxygen and stated she was aware she should have informed the physician. An interview conducted with the Director of Nursing (DON) on 05/17/12, at 2:50 PM, revealed nurses were required to ensure oxygen was administered in accordance with physician's orders and that Resident #11 should have received oxygen at 2 liters by nasal cannula as the physician had ordered. The DON also stated the physician of Resident #11 should have been contacted after the resident was observed to take off his/her oxygen or to change the settings.	F 328	F # 364 1. No residents were found to have been adversely affected by this practice. 2. All residents with oral diets have the potential to be affected. 3. The RD inserviced the dietary manager and all dietary staff on 6/7/12 regarding required temperature for foods. The SDC inserviced all nursing staff on 5/24/12 and 5/25/12 related to time frame to serve trays and when to have trays replaced for food to be at its most palatability and appropriate temperature. Dietary staff will test and record temperature of trays with each meal prior to sending the trays to the units to be served. Nursing staff will serve all meal trays in 15-20 minutes after receiving them on the unit. Any tray not served in 15-20 minutes will be returned to the kitchen to be replaced with a new meal.		
F 364 SS#E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was palatable and at the proper temperatures when served to residents. Observations of the evening meal on 05/15/12, revealed a resident meal tray left on the tray cart for thirty-five minutes before served to the resident and during the breakfast meal on	F 364	4. Dietary Manager will audit tray temperatures daily (Monday through Friday) x 1 week, weekly x 4 weeks,		

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F 364	<p>Continued From page 24</p> <p>05/17/12, a meal tray was left on the cart for forty-five minutes before being served. The facility had no guidelines for staff to follow to ensure meals were served to residents at palatable temperatures.</p> <p>The findings include:</p> <p>A review of the facility policy for Resident Dining services, dated 01/01/07, revealed residents were to receive meals at proper temperatures. The policy had no guidelines for staff related to the length of time a meal tray should be left on the cart before requesting a replacement.</p> <p>1. Observation of the evening meal service on 05/15/12, at 5:00 PM, revealed a cart of meal trays was delivered to the Hope Unit. The last tray to be delivered from the meal cart was intercepted at 5:35 PM, and a palatability test was conducted with the Dietary Manager (DM). The ground meat was 104 degrees Fahrenheit and tasted lukewarm; the carrots were 91 degrees Fahrenheit and tasted lukewarm; the lima beans were 104 degrees Fahrenheit and tasted lukewarm; and the buttermilk was 63 degrees Fahrenheit and tasted cool but not cold.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #1 on 05/15/12, at 5:50 PM, revealed it usually takes from 35 to 45 minutes to pass the evening trays. The SRNA stated if the trays were on the cart longer than one hour they should be sent back to the kitchen for replacement. The SRNA stated she had not been told by the facility how long a tray should be allowed to sit before being replaced to ensure the foods were palatable before serving to residents.</p>	F 364	<p>and monthly x 4 months to ensure temperatures are being maintained during tray service. She will audit tray temperatures in regards to time daily (Monday-Friday) x 1 week, weekly x 4 weeks, and monthly x 4 months to ensure trays are palatable, at preferred temperatures, and passed within 15-20 minutes upon delivery to units.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance- June 25, 2012.</p>	

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F 364	<p>Continued From page 25</p> <p>An interview conducted with SRNA #2 on 05/15/12, at 5:55 PM, revealed it usually took 35 to 45 minutes to pass the evening trays. The SRNA stated she had not been told by the facility how long would be too long for a tray to be on the tray cart before being sent back to the kitchen for replacement, however, she felt that they should not be allowed to sit for longer than ten minutes.</p> <p>An interview conducted with SRNA #3 on 05/15/12, at 6:00 PM, revealed the SRNA stated it usually takes at least 30 minutes to pass the evening trays. The SRNA stated she had never been told by the facility how long would be too long for a tray to be on the tray cart before being sent back to the kitchen for replacement, however, she felt that they should not be allowed to sit for longer than ten minutes.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 05/15/12, at 6:05 PM, revealed she was responsible to ensure care was provided for the residents on the Hope Unit and to ensure meal trays were delivered to the residents timely and at palatable temperatures. The RN stated it usually takes 25 to 30 minutes for the SRNAs to deliver the trays to the residents and that no tray should be allowed to sit on the tray cart for longer than 30 minutes before sending it back to the kitchen to be replaced, although the RN was unaware of any facility guidelines to indicate how long a tray should remain on the tray cart.</p> <p>An interview with the Dietary Manager (DM) on 05/15/12, at 5:40 PM, revealed the trays should have been delivered to the residents within 15 minutes or they should have been sent back to</p>	F 364		

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F 364	<p>Continued From page 26</p> <p>the kitchen to be replaced. The DM stated she monitors one cart of meal trays every month and alternates between the meals. The DM further stated it had been two months since she had monitored the supper meal for delivery time and temperatures and had not identified any problems with the meal service.</p> <p>An interview conducted with the Director of Nursing (DON) on 05/17/12, at 2:50 PM, revealed she was unsure how long a tray should be allowed to sit on a tray cart before being sent back to the kitchen to be replaced. The DON stated she felt trays should not be allowed to sit for longer than 15 minutes.</p> <p>2. Observations of the breakfast meal on the Rose Garden on 05/17/12, revealed trays sat on the delivery cart in the hallway for a total of 45 minutes. The temperatures were obtained on the last food tray off the cart with LPN #2 present. The temperatures were: pureed scrambled eggs - 100 degrees Fahrenheit, pureed bacon - 90 degrees Fahrenheit, gravy - 100 degrees Fahrenheit, oatmeal - 110 degrees Fahrenheit, pureed biscuit - 92 degrees Fahrenheit, whole milk - 58 degrees Fahrenheit, and orange juice - 60 degrees Fahrenheit.</p> <p>Interview with LPN #2 on 05/17/12, at 8:47 AM, revealed the milk should not be that warm, and the bacon and gravy were too cold to eat. The LPN stated the meal service usually takes at least 45 minutes to serve breakfast.</p> <p>Interview with CNA #13 revealed the Rose Garden always took 45 minutes to serve breakfast trays, and sometimes longer.</p>	F 364		

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F # 441 (Part I)</p> <ol style="list-style-type: none"> Resident A and B were not found to have been adversely affected by this practice. All resident's receiving oral diets have the potential to be affected. A 100% observation will be completed by 6/8/12 by the Nursing Management Team of meals served for hand washing guidelines, not touching food with bare hands, and when to wear gloves. The SDC inserviced all staff 5/24/12 and 5/25/12 regarding hand washing guidelines, not touching food with bare hands, and when to wear gloves. <p>A licensed nurse has been assigned to the dining rooms during meal times to oversee the meal process. The Infection Control Nurse will observe for hand washing, use of hand sanitizer, and wearing gloves when needed.</p>	

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F 441	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary environment to prevent the development and transmission of disease and infection. On 05/16/12, observation revealed staff failed to use Personal Protective Equipment as required for one of twenty residents selected for review (Resident #3). Based on observation, staff was to utilize contact/droplet precautions when providing care to Resident #3, however, staff was observed to provide care to the resident without utilizing the identified precautions and failed to utilize the identified precautions. In addition, staff was observed during the breakfast meal on 05/17/12, to directly touch food items (biscuits/toast) without the use of utensils or gloves for two unsampled resident (Residents A and B).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the facility's Transmission Based Precautions and Isolation Precautions policy, dated 07/18/11, revealed the facility had procedures to explain Standard and Transmission Based Precautions and to communicate information about residents with potentially transmissible infectious agents. According to Contact Precautions policy/procedure, the use of gloves and gown was required during any provision of care for a resident that had tested positive for Vancomycin Resistant Enterococcus 	F 441	<ol style="list-style-type: none"> 4. The Infection Control Nurse will complete audits daily (Monday through Friday) x one week, weekly x 4 weeks, monthly x 2 months, and randomly to ensure hands are being washed when toughing or providing services for residents, not touching food with bare hand, and wearing gloves when needed. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance – June 25, 2012. <p style="text-align: center;"><u>F # 441 (Part 2)</u></p> <ol style="list-style-type: none"> 1. The Unit Coordinator was inserviced by the Director of Nursing for proper isolation precautions and the use of personal protective equipment needed to care for resident # 3 along with competency.. 2. A 100% audit of all resident's requiring isolation was completed by the Infection Control Nurse on 5/31/12 to ensure that all isolation precaution guidelines were being followed. No other residents were affected. 3. The SDC inserviced all licensed and certified staff on 5/24/12 and 5/25/12 regarding isolation precautions and proper use of personal protective equipment. 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 660 ELKHORN CITY, KY 41522		
(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	<p>Continued From page 29</p> <p>(VRE) and Methicillin Resistant Staph Aureus (MRSA).</p> <p>A review of documentation revealed the facility admitted Resident #3 on 05/10/12, with Vancomycin Resistant Enterococcus (VRE) of the rectum and Methicillin Resistant Staph Aureus (MRSA) of the sputum. Resident #3 received antibiotics as indicated as treatments for the infections.</p> <p>An observation of staff on 05/16/12, at 9:15 AM, revealed the Unit Coordinator entered the room of Resident #3 to provide care, however, the Coordinator failed to apply the Personal Protective Equipment (PPE), including gowns, gloves, and masks for droplet/contact precautions in accordance with the facility's Contact Precautions policy prior to entering the resident's room.</p> <p>An interview conducted on 05/16/12, at 1:30 PM, with the Unit Coordinator revealed she was not required to utilize a gown with droplet precautions unless the resident was coughing or sneezing.</p> <p>An interview was conducted with the facility Infection Control Nurse on 05/16/12, at 4:00 PM. The Infection Control Nurse stated residents with MRSA of the sputum were required to have droplet precautions. The Infection Control Nurse further stated that Resident #3 was required to have droplet precautions. The Infection Control Nurse stated the facility staff was in-serviced on all types of isolation and the PPE equipment required for potential transmissible infectious agents.</p>	F 441	<p>4. The Infection Control Nurse will observe residents requiring isolation to ensure that isolation precaution guidelines are being followed and for proper use of personal protective equipment. These audits will be conducted daily Monday through Friday x 30 days, weekly x 4 weeks, monthly x 2 months, then randomly.</p> <p>5. Date of Compliance – June 25, 2012.</p>	

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F 441	Continued From page 30 2. A review of the Infection Control policy dated 07/18/11, revealed staff was not to directly touch residents' food without the use of utensils or gloves. Observation of the breakfast meal on 05/17/12, on the Rose Garden unit at 8:25 AM, revealed Certified Nurse Aide (CNA) #3 picked up Resident B's toast with bare hands and applied jelly to the toast and failed to use utensils/gloves when touching the food. Continued observations of the breakfast meal revealed the Assistant Activities Director picked up and crumbled Resident B's biscuit with bare hands and without the use of utensils or gloves. Interview with CNA #13 on 05/17/12, at 8:25 AM, revealed the CNA knew to apply gloves first, and had been trained in the proper way to handle residents' food but stated, "I just got nervous and forgot to put on my gloves." Interview with the Assistant Activities Director on 05/17/12, at 9:00 AM, revealed the Assistant Activities Director did not know to utilize gloves prior to handling residents' food.	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F 456			

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F 456	<p>Continued From page 31</p> <p>facility policy/procedure it was determined the facility failed to ensure the equipment in use at the facility was maintained in safe operating condition as evidenced by the nutrition refrigerator in the Faith Hall with a temperature of fifty-two degrees on 05/17/12 (proper temperature range is 32 degrees to 40 degrees Fahrenheit per facility log). Additional observations revealed there was no thermometer in the food refrigerator on the Rose Garden Wing. In addition, on 05/17/12, the walk-in cooler had a buildup of ice and frozen condensation on the back wall under the fan motor box.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility policy/procedure, House Nourishment/Snacks, (no date provided) revealed nourishment refrigerator temperature logs would be recorded daily by Housekeeping. The facility policy/procedure did not identify proper temperatures; however, the refrigerator temperature log maintained by the facility listed a range of 32 degrees Fahrenheit (F) to 40 degrees F. <p>Observations on 05/17/12, at 6:00 AM, of the nourishment refrigerator on the Faith Hall revealed a temperature of 50 degrees Fahrenheit, 10 degrees above the temperature range recommended by the facility log. The refrigerator contained five cartons of whole milk, three cartons of fat-free milk, a loaf of white bread, a package of processed cheese slices, one container of Hi-Pro dietary supplement, one carton of thickened apple juice, and one quart container of punch. Observations of the nutrition refrigerator on the Rose Garden Wing revealed</p>	F 456	<p>F # 456</p> <ol style="list-style-type: none"> Refrigerator temperatures were readjusted by Maintenance Director on 5/18/12, all food and beverages were discarded, all refrigerators were restocked, and new thermometers were place in all refrigerators. The walk-in freezer was defrosted and assessed by the Maintenance Director for proper functioning on 5/17/12. Osborne Reprigeration scheduled to assess walk in freezer on 6/11/12. All resident's had the potential to be affected. A 100% review of all refrigerators and walk-in freezer was conducted on 5/18/12 to ensure that all refrigerators and walk-in freezer had temperature within the guidelines and functioning properly. Housekeeping supervisor and housekeeping staff were inserviced on 6/6/12 by Executive Director on the regulated guidelines for refrigerator temperatures. Education was provided on the importance of the temperatures being within the appropriate range and daily documentation. Any refrigerator having a temperature outside of the appropriate range will be reported to the Maintenance Director, by completing a maintenance request form, to be assessed and/or replaced. 		

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F 456	<p>Continued From page 32 the refrigerator did not have a thermometer present.</p> <p>Review of the refrigerator temperature logs maintained by the facility revealed on 05/16/12, the temperature in the nourishment refrigerator on the Faith Hall was 58 degrees Fahrenheit. There was documentation that the refrigerator had been put out of service; however, the refrigerator was observed to be utilized by staff during observation on 05/17/12. Further review of the refrigerator temperature logs revealed the temperature of the refrigerator in the Rose Garden had not been documented since 05/14/12, a timeframe of three days.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 05/17/12, at 6:05 AM, revealed the LPN was unaware the thermometer was missing from the Rose Garden refrigerator. According to the LPN, night shift nursing staff was required to check the refrigerator temperatures.</p> <p>Interview with LPN #3 on 05/17/12, at 6:14 AM, revealed LPN #3 worked the night shift in the facility on the Faith Hall. According to LPN #3, the nourishment refrigerator was to be checked once a day but the LPN was unaware of who was responsible for ensuring the refrigerator was checked. The LPN stated she did not check the refrigerator on her shift.</p> <p>Interview with Housekeeping staff on the Faith Hall on 05/17/12, at 7:15 AM, revealed Housekeeping staff was responsible for checking the nourishment refrigerator temperatures once a week and documenting the temperatures on the log.</p>	F 4: 4	<p>Housekeeping personnel will observe and report refrigerator temperatures daily. Housekeeping Supervisor will monitor logs Monday thru Friday daily. Executive Director and Maintenance Director will do random audits daily times 30 days.</p> <p>Dietary Manger will monitor walk-in freezer for condensation daily x 30 days, weekly x 4, monthly x 2 then random.</p> <p>5. Date of Compliance – June 25, 2012.</p>	

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F 456	Continued From page 33 2. Observation of the facility walk-in freezer on 05/17/12, revealed the freezer had a two inch thick buildup of ice and frozen condensation accumulated under the fan motor box in the rear wall of the walk-in freezer. This ice and frozen condensation had the potential to prevent proper functioning of the fan motor of the freezer and to contaminate the frozen foods stored under the fan motor box. An interview was conducted with the facility Dietary Manager on 05/17/12, at 9:30 AM. The Dietary Manager stated that he/she was unaware the freezer fan/condenser line had leaked and that a buildup of ice had occurred.	F 456		

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R E C E I V E D

JUN - 8 2012
05/17/2012

Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 40522
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1980</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type III (unprotected)</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in laundry and kitchen area.</p> <p>Sprinkler System: Complete sprinkler system (dry).</p> <p>Generator: Type 2 generator powered by diesel</p> <p>A standard Life Safety Code survey was conducted on 05/17/12. Mountain View Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 102. The facility is licensed for 106 beds.</p> <p>The highest scope and severity deficiency was at "D" level.</p>	K 000		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are</p>	K 062	<p style="text-align: center;">Tag 062</p> <ol style="list-style-type: none"> 1. Maintenance Director and assistant immediately started rerouting wires that was wrapped around the sprinkler pipes on 5/18/12 and job was complete on 5/21/12. 2. All residents could have been affected. 3. Executive Director educated Maintenance Director and assistant on inspecting contracted services to ensure that no wiring is obstructing any sprinkler piping or sprinkler head per state regulation guidelines. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Hilda Stidham RN</i>	TITLE DON	(X6) DATE 6-8-12
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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 062	<p>Continued From page 1</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinklers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of five smoke compartments, twenty-four residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 05/17/12, at 10:21 AM, revealed wiring was attached to the sprinkler piping. Further observation revealed the wiring had obstructed a sprinkler head. No items can be attached to sprinkler piping and sprinkler heads cannot be obstructed. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 05/17/12, at 10:23 AM, with the Maintenance Director revealed he was unaware the wiring was attached to the sprinkler piping and the sprinkler head was obstructed.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected. 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition</p>	K 062	<p>4. Maintenance Director or assistant will inspect sprinkler pipes and sprinkler heads when any new service requiring wiring has been provided and then annually.</p> <p>5. Completion date is 6/25/12</p>		

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K 062	Continued From page 2 and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain two of twenty-four fire extinguishers in the facility. The deficiency had the potential to affect one smoke compartment, three residents, staff, and visitors. The findings include: Observation on 05/17/12, at 11:51 AM, revealed a fire extinguisher located at the resident smoking shed did not have a service collar that indicated a service date. The fire extinguisher had a manufacture date of 2002. Fire extinguishers must have a service collar indicating that the extinguishers have been emptied, internally	K 064	Tag 064 1. Maintenance Director notified Eastern Telephone technology on 5/17/12 regarding 2 fire extinguishers that did not have a service collar indicating a service date within the last six years. These two extinguishers were replaced on 6/1/12 with all extinguishers to be replaced by 6/8/12. 2. All residents had the potential to be affected. 3. Executive Director educated Maintenance Director and assistant on 6/6/12 regarding the state regulation guidelines on fire extinguishers having a service collar every six years indicating that they had been emptied, internally examined, and recharged. 4. Maintenance Director/Assistant will maintain a log of all fire extinguisher service dates. 5. Completion date is 6/25/12	

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K 064	<p>Continued From page 3</p> <p>examined, and recharged every six years. Further observation revealed the fire extinguisher located in central supply did not have a service collar. The fire extinguisher had a manufacture date of 1978. The observation was confirmed with the Director of Maintenance.</p> <p>Interview on 05/17/12, at 11:51 AM, with the Director of Maintenance revealed the facility depends on a contractor to maintain these items.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.</p> <p>4-4.4* Maintenance Recordkeeping. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service.</p> <p>4-4.4.1* Fire extinguishers that pass the</p>	K 064			

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K 064 Continued From page 4
applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 1 1/2 in. (5.1 cm x 3.8 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:
(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch
(b) Name or initials of person performing the maintenance and name of agency performing the maintenance.

4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.
Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.
Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.

K 064

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K 130 SS=D	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors that could be confused as an exit were identified, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of five smoke compartments, nine residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 05/17/12, at 11:22 AM, with the Maintenance Director, revealed three doors located in the Back Dining Room, exited into an interior courtyard, and was not used as an emergency exit. The three doors were not identified with signage stating, NO EXIT. Doors that can be confused as an exit must be identified by a sign.</p> <p>Interview on 05/17/12, at 11:22 AM, with the Maintenance Director, revealed he was not aware the signs were missing from the three doors.</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:</p> <p>NO</p>	K 130	<p>Tag 130</p> <ol style="list-style-type: none"> Maintenance Director ordered signs for all doors leading to the court yard on 5/18/12. Signs received and placed on 5/31/12 that stated "this is not an exit". All residents had the potential to be affected. Executive Director educated Maintenance Director and assistant on state regulation regarding signage for none exit doors on 6/7/12. Maintenance Director/Assistant will monitor none exit doors signage during rounds daily times 30 days, weekly times 4, monthly times 2, then randomly. Completion date 6/25/12 	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522
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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 130	<p>Continued From page 6 EXIT</p> <p>Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.</p>	K 130		
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