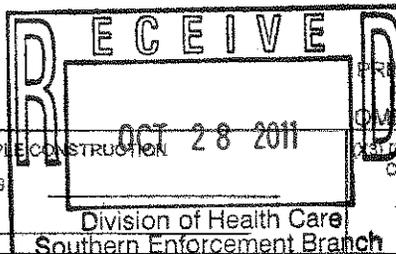


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/06/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
----------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 A standard health survey was conducted on 10/04-06/11. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY17083) was also conducted at this time. The complaint was substantiated with related deficiencies.	F 000	The preparation and execution of this plan does not constitute admission or agreement by the provider, of truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and state law.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.	F 164	F-164 It is the policy and culture of this facility to provide for the personal privacy for all of the residents of Cedars of Lebanon Nursing Center. 1. The resident was immediately provided privacy by Staff Development Nurse. The contract Rehab Speech Language Pathologist (SLP) was removed from the facility and replaced. 2. The Facility immediately performed evaluations on the rehab providers cases and all other residents in the facility to determine if other residents had been affected by the deficient practice. No other residents were found affected by practice. 3. All staff were reeducated through the use of in-services conducted on 10/17/11-10/18/11, which detailed the proper procedure for providing privacy, maintaining dignity, understanding the needs of residents while performing care for a resident in their environment. (See Exhibit # 1, Privacy and Dignity In-service sign in sheet for rehab and Exhibit # 1A Privacy and Dignity In-service sign in sheet for facility)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robbie Euthorn</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/28/11</i>
------------------------------------------------------------------------------------------------	-------------------------------	------------------------------

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.

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide visual privacy for one of seventeen sampled residents (Resident #11). The findings include: Review of the facility's policy titled Privacy and Confidentiality (effective date 10/01/07) revealed residents had a right to personal privacy during medical treatments and privacy of the resident's body would be maintained during examinations and treatments. Review of the record revealed the facility admitted Resident #11 on 05/20/11, with diagnoses of Down's Syndrome, Severe Mental Retardation, Seizure Disorder, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 08/11/11, revealed Resident #11 required extensive assistance to total assistance from staff for all activities of daily living. Observation on 10/05/11, at 9:35 AM, revealed Resident #11 in his/her room and in plain view from the nurses' station. Continued observation revealed a Speech/Language Pathologist (SLP) entered Resident #11's room. The SLP attached small electrodes to Resident #11's neck to initiate a treatment of Vital Stimulation (an external electrical current to stimulate the muscles responsible for swallowing). Further observation revealed the SLP failed to ensure personal privacy was provided during the treatment and	F 164	F-164 Continued 4.A quality instrument will be utilized by Director of Nursing or ADON to evaluate residents privacy considerations by the staff while performing care that privacy curtains are pulled together appropriately, doors are closed (See Exhibit # 2, privacy/dignity monitor). If there are any indications that a residents privacy may be jeopardized the DON/ADON will remind and provide appropriate one on one education with the staff member before an incident occurs. The DON/ADON, will provide the quality forms weekly for evaluation and review with the Continuous Quality Committee (Morning Stand Up). This process will continue on a weekly basis for the period of not less than one month, longer if less than 100% compliance is met, The quality evaluation will continue to be performed three times per week at random by the DON or ADON for the period of not less than one month until 100 % compliance is maintained.		

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 164	Continued From page 2 the resident remained in plain view. The SLP assisted the resident to drink during the Vital Stimulation and provided oral care all in view of staff and visitors that were in the hallway or near the nurses' station. The resident responded by making incoherent sounds as though having some discomfort with the treatment. An interview conducted on 10/06/11, at 9:10 AM, with the SLP revealed Vital Stimulation was provided to activate/strengthen the throat muscles responsible for swallowing. The SLP stated the treatment could produce discomfort as the electrical current stimulated/squeezed the muscles. The SLP stated the intensity of the treatment should be adjusted according to the resident's reaction or if the resident was able to verbally express the discomfort. The SLP stated the intensity of the treatment for Resident #11 required lowering because the resident made incoherent sounds. The SLP stated privacy should be provided during any treatment and she just failed to close the door. The SLP was unaware a privacy curtain was available for the resident in the first bed located nearest the door.	F 164	F-164 Continued. The Administrator will then poll five random residents to monitor dignity and privacy, once weekly for one month until 100% compliance is maintained. (See Exhibit #2, privacy and dignity monitor) and report findings to the Quality Assurance Committee for determination if further action plans are needed.	10/28/2011	
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, interview, record review,	F 241	F-241 1.The signage was immediately removed by Staff Development Nurse. The contract Rehab Speech Language Pathologist (SLP) was removed from the facility and replaced.		

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 241	<p>Continued From page 3</p> <p>and review of facility policy, the facility failed to promote care in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for one of seventeen sampled residents (Resident #11).</p> <p>The findings include:</p> <p>Review of the facility's policy titled Resident's Rights/Federal Law (dated 10/2007) revealed residents had a right to personal privacy and confidentiality of his/her personal and clinical records.</p> <p>Review of the record revealed the facility admitted Resident #11 on 05/20/11, with diagnoses of Down's Syndrome, Severe Mental Retardation, Seizure Disorder, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 08/11/11, revealed Resident #11 was severely impaired in daily decision-making and required extensive to total assistance for all activities of daily living.</p> <p>Observation on 10/05/11, at 9:00 AM, revealed a sign was taped to the wall above Resident #11's bed. The sign listed the resident's name, room number, and had in large bold letters that were highlighted: "Patient is A Silent Aspirator" and "Patient does not cough or choke when food/liquid enters the airway. Sit upright at 90 degrees. Stay upright for at least 30 minutes after taking anything by mouth." Further observation revealed the sign was dated 07/20/11, and signed by the Speech/Language Pathologist (SLP).</p> <p>Interview on 10/06/11, at 9:10 AM, with the SLP</p>	F 241	<p>F-241 Continued</p> <p>2. The Director of Nursing immediately performed evaluations on the rehab providers cases and all other residents to determine if other residents had been affected by the deficient practice. No other residents were found affected by practice.</p> <p>3.All staff were reeducated through the use of in-services conducted on 10/17/11-10/18/11, which detailed the proper procedure for providing privacy, maintaining dignity, understanding the needs of residents while performing care for a resident in their environment. (See Exhibit # 1 and 1A, Privacy, and Dignity In-service)</p> <p>4.A quality instrument will be utilized by Director of Nursing or ADON to evaluate residents privacy considerations by the staff while performing care that privacy curtains are pulled together appropriately, doors are closed (See Exhibit # 2, privacy/dignity monitor). If there are any indications that a residents privacy may be jeopardized the DON/ADON will remind and provide appropriate one on one education with the staff member before an incident occurs. The DON/ADON will provide the quality forms weekly for evaluation and review with the Continuous Quality Committee (Morning Stand Up).</p>		

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 241	Continued From page 4 revealed the signed was posted by the SLP. The SLP stated she had in-serviced staff on the proper feeding techniques required for Resident #11, and had posted the sign over Resident #11's bed to remind staff of the feeding requirements. The SLP also stated she was concerned for the safety of the resident during meals and felt by posting the sign the risk would outweigh the privacy/confidentiality issue. Interview on 10/06/11, at 9:30 AM, with the Unit Coordinator (UC) revealed she was not aware of the feeding instructions sheet being posted above Resident #11's bed. The UC stated residents' private information should not be posted.	F 241	F-241 Continued This process will continue on a weekly basis for the period of not less than one month, longer if less than 100% compliance is met, The quality evaluation will continue to be performed three times per week at random by the DON or ADON for the period of not less than one month until 100 % compliance is maintained. The Administrator will then poll five random residents to monitor dignity and privacy,once weekly for one month until 100% compliance is maintained. (See Exhibit #2, privacy and dignity monitor)and report findings to the Quality Assurance Committee for determination if further action plans are needed.	10/28/11	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide effective housekeeping and maintenance services necessary to ensure a sanitary, orderly, and comfortable environment. Water temperatures were below the recommended temperatures on 10/04/11, on the Raley Hall, a footboard was broken with sharp edges exposed in room 145A, the shower chair on the Davis Hall had frayed edges, and three wheelchair armrests were torn and in need of	F 253	F-253 1.A. Water Temperatures- Lanham HVAC was immediately notified a inspection revealed faulty piping and mixing valve. These items were immediately repaired. (See Exhibit #3, Lanham refrigeration). B. Footboard located in room 145-A was immediately repaired. (See Exhibit #4, work order for footboard) C. Shower chair located on Davis Hall- Shower chair had already been scheduled for replacement which arrived after survey (See Exhibit #5, shower chair invoice) D. Wheelchair arms located in rooms 104, 125,138 were replaced with new ones immediately. (See Exhibit #6, work order wheelchair arm replacement) E. "Mold like" substance Located in Davis Hall shower- was immediately scrubbed out of existence and sanitized by maintenance. (See Exhibit # 7, work order, cleaning of Davis Hall shower/grout)		

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 253	<p>Continued From page 5</p> <p>repair. In addition, the tile grout in the shower room on the Davis Hall had a black "mold like" substance and was in need of cleaning.</p> <p>The findings include:</p> <p>A review of the facility policy Monitoring Water Temperatures (effective 10/01/07) revealed the water temperatures were to be monitored weekly, documented on a log, and water temperatures outside the recommended safe range of 105 degrees Fahrenheit and 120 degrees Fahrenheit would be addressed immediately. However, in accordance with the State Operations Manual, the water temperature should be 100 to 110 degrees Fahrenheit.</p> <p>Observations during the environmental tour on 10/04/11, at 11:05 PM, revealed the water temperatures on the Raley Hall ranged from 88 degrees Fahrenheit to 94 degrees Fahrenheit and were below the State Operations Manual's recommended safe water temperatures of 100 to 110 degrees Fahrenheit. In addition an environmental tour conducted with the Maintenance Director on 10/06/11, at 10:00 AM, revealed the following areas in need of cleaning/repair: A footboard on bed A in Room 145 was broken and sharp edges were exposed; the seat of the shower chair in the Davis shower room was observed to consist of a plastic fabric that was frayed and sharp; the tile grout on the floor and wall in the Davis shower room was observed to be discolored with a black "mold like" substance and was in need of cleaning; and the arm rests on three wheelchairs located in rooms 104, 125, and 138 were in need of repair.</p>	F 253	<p>F-253 Continued.</p> <p>2.A general wear and cleanliness inspection was conducted at that time(See Exhibit # 8, Monthly general wear inspection form) to determine if any additional residents were affected by the practice. Water temperatures were also monitored throughout the facility to ensure that there were no additional issues with low water temperatures. (See Exhibit # 9, water temperature monitoring form)</p> <p>3. A system review was conducted and the shower areas and general cleanliness was added to the monthly general safety inspection for each room.</p> <p>Policy for obtaining water temperatures was updated and in serviced on 10/06/11.(See Exhibit #10, Water temperature policy update)</p> <p>4.A monthly general wear and cleanliness monitor was added to the safety rounds (See Exhibit #8 Monthly general wear inspection)</p> <p>A water temperature monitor was updated to reflect varying times of obtaining temps, to include second and third shifts. Temps are to be monitored on all shifts by maintenance weekly and reported to Interdisciplinary Team (IDT) daily for any issues and monthly to Quality Assurance.</p>	10/13/11	

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 253	<p>Continued From page 6</p> <p>Interview with Certified Nursing Assistants (CNAs) #1 and #2 on 10/04/11, at 11:17 PM and 11:40 PM, revealed the facility did not always have hot water during the third shift. The staff stated if a resident required a bed bath, a pan of hot water could be obtained from the kitchen and mixed with cold water to provide the needed warm water to bathe/provide care for residents. The CNAs stated Nursing staff was aware of the lack of hot water available on the nursing units to provide care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/04/11, at 11:22 PM, revealed the Laundry/Housekeeping staff turns the hot water off before they leave at 10:30 PM, and turns the hot water on when they come in the next morning. The LPN stated showers were provided during the first shift and there had never been an issue with water being too cold during the first shift; however, incontinence care was provided by CNAs during the third shift, and the issue of cold water during that shift had been reported to the Director of Nursing.</p> <p>Interview with the Director of Nursing (DON) on 10/04/11, at 11:45 PM, revealed the third shift nurses had recently made her aware within the past several weeks that the water was cold during the night shift and that she had notified the Administrator of the cold water temperatures on 09/15/11. The DON was not aware Laundry/Housekeeping staff was "turning off" the hot water at night. The DON stated the facility had been working on the "mixing valve," trying to adjust the water temperatures.</p> <p>Interview with laundry aide #1 on 10/05/11, at</p>	F 253			

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 253	<p>Continued From page 7</p> <p>10:00 AM, revealed the aide came in at 4:30 AM, and worked until 2:00 PM. The laundry aide said the breaker for the washing machines in the laundry room was in the "off" position at the beginning of the shift at 4:30 AM, and staff had to turn the breaker on to have access to hot water during the shift. The laundry aide also stated she had been at the facility for four years and was taught to turn the breaker off when she left for the day, and would turn the breaker off at the end of the shift at 2:00 PM.</p> <p>Interview with housekeeping aide #1 on 10/05/11, at 3:20 PM, revealed his normal hours were from 2:00 PM to 10:00 PM. The aide stated if a load of laundry needed to be washed he would turn the washing machine breaker on and would turn the breaker off when the laundry was completed.</p> <p>Interview with the Administrator on 10/05/11, at 8:30 AM, revealed he had been made aware by the DON on the morning of 09/15/11, that there was a lack of hot water in the facility. The Administrator reportedly had a repairman work on the water system and the Administrator thought the problem with a lack of hot water had been "fixed."</p> <p>An interview with the Maintenance Director on 10/05/11, at 3:30 PM, revealed water temperatures were monitored weekly in different areas of the building but were not monitored on different shifts. The Maintenance Director stated when the temperatures were outside of the safe range the mixing valve was usually the reason, and a plumber was called in to take care of the problem. The Maintenance Director was unaware the washing machine breaker had</p>	F 253			

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033	
(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 253	Continued From page 8 anything to do with insufficient hot water. In addition, although the Maintenance Director was aware the breaker was turned off at night, he was unaware the water from the hot water system was too cold for bathing or the provision of incontinence care during the third shift. In addition, the Maintenance Director was unaware of the torn armrests on the wheelchairs and stated new armrests were available in the facility. The Maintenance Director stated the tile in the Davis shower room was extremely difficult to keep clean and that the footboard in room 145 and the worn/torn shower chair would need to be replaced.	F 253		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, medical record reviews, and review of facility policy/procedure it was determined the facility failed to ensure one of fifteen sampled residents (Resident #6) received the appropriate services to prevent aspiration pneumonia. Resident #6 was observed on 10/05/11, to be lying in bed with the head of the bed elevated approximately 10 degrees while receiving a continuous	F 322	F-322 1. Resident head of bed was immediately moved to 30 degrees, resident was assessed for any potential aspiration and found to be negative. The SRNA was counseled and reeducated immediately. (See Exhibit #11, SRNA counseling form). Kardex was immediately updated to reflect residents plan of care. 2. All residents that had tubes in place were evaluated and it was determined that no others were affected by the care. 3. Feeding tube policy was updated to reflect the changes on the Kardex at all times. SRNA and licensed staff in serviced on policy 10/18/11 (See Exhibit # 12, Feeding tube policy and sign in sheet).	

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/06/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
----------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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 322	<p>Continued From page 9 gastrostomy tube feeding.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure "Feeding Tubes Gastrostomy, PEG, etc." (dated as revised 09/23/08) revealed residents who received tube feedings must have the head of the bed elevated 30 degrees at all times.</p> <p>Review of the physician's orders for Resident #6 dated 03/12/11, revealed the head of the resident's bed was to be elevated 30-45 degrees at all times during feeding and at least 30-40 minutes after the feeding was stopped.</p> <p>Observation of Resident #6 on 10/05/11, from 8:45 AM to 12:15 PM, revealed the resident to be receiving nutrition via a gastrostomy tube. The feeding was delivered via a feeding pump at 50 cc (cubic centimeters) per hour continuously. The head of the resident's bed was elevated approximately 30 degrees. Observations on 10/05/11, at 1:40 PM, revealed Resident #6 in bed receiving the tube feeding at 50 cc per hour. The head of the resident's bed was not elevated and the resident was lying flat.</p> <p>Review of the comprehensive care plan for Resident #6 dated as revised on 04/26/11, revealed staff was required to elevate the head of the resident's bed 30-45 degrees at all times during feeding.</p> <p>Interview on 10/05/11, at 1:40 PM, with State Registered Nursing Assistant (SRNA) #6 revealed SRNA #6 was responsible for the care of Resident #6. The SRNA stated she had</p>	F 322	<p>F-322 Continued</p> <p>4. Quality Monitor for residents receiving nutrition through enteral or any tube feeding was developed. (See Exhibit # 13, Quality Monitor for residents receiving nutrition through enteral feeding or other tube, the Head of bed is to be at 30 degrees). The Director of Nursing, ADON will perform the audit daily for 7 days until 100 % compliance has been achieved, then three times weekly for three weeks until 100% compliance has been achieved. Then monthly for three months or until 100% compliance is maintained. The Administrator will audit quality monitor for compliance at least weekly utilizing the HOB monitor form.</p> <p>Any suspected discrepancies will be remedied immediately. The quality monitor will be reviewed, reported and discussed with the Quality Assurance Committee for recommendations on monthly basis if needed.</p>	10/18/11

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 322	Continued From page 10 repositioned the resident prior to 1:40 PM, and was unaware the head of the resident's bed was not elevated as required. Interview with SRNA #5 on 10/05/11, at 1:45 PM, revealed all residents receiving tube feedings were to have the head of the bed elevated 45 degrees at all times. SRNA #5 stated the head of Resident #6's bed was too low and should have been elevated. Interview with the Director of Nursing (DON) on 10/05/11, at 1:50 PM, revealed SRNAs were required to consult the resident Kardex for all care needs. The DON stated all care needs for residents were on the Kardex. Upon review of the Kardex the DON stated there was no requirement for the resident's head to be elevated 30-45 degrees on the Kardex but it should have been documented.	F 322			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Dietary Sanitation policy, it was	F 371	F-371 1. The range hood was immediately cleaned and disinfected, relieving the appliance of all dust and debris. 2. Given the the practice involved the range hood that is part of the food preparation for all residents, it was determined by IDT that all residents had the potential to have been affected.		

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 371	<p>Continued From page 11</p> <p>determined the facility failed to prepare and distribute food under sanitary conditions. Observations revealed an excessive accumulation of dust on the gas range hood vent cover.</p> <p>The findings include:</p> <p>A review of the facility policy Dietary Sanitation (dated 10/01/07) revealed cleaning schedules for all equipment and areas of the Dietary Department were to be posted. In addition, according to policy, staff members assigned to clean the equipment were to document the equipment had been cleaned. The cleaning schedules were to be monitored on a daily basis by the Dietary Manager to verify staff had cleaned the equipment.</p> <p>Observation during the kitchen tour on 10/04/11, at 3:05 PM, revealed vents in the hood over the gas range were covered with a brown buildup of dust. The vent covers were located directly over the burners of the stove.</p> <p>An interview with the Dietary Manager (DM) on 10/04/11, at 3:10 PM, revealed the facility had an agreement with a company to pressure wash the vents every six months. According to the DM, the vents were scheduled to be cleaned in November 2011. The DM acknowledged the stove vent covers needed to be cleaned and that dust from the vents could fall into the residents' food while it was cooking.</p>	F 371	<p>F-371</p> <p>3. The kitchen staff will provide routine cleaning of the range hood every month in addition to the contracted cleaning once per quarter. (See Exhibit #14, range hood cleaning inspection)</p> <p>4. The Administrator will monitor the monthly cleaning of the range hood every month x 3 months until 100% compliance has been achieved then every other month for 9 months.</p>	10/10/11	