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

OFFICE OF INSPECTOR GENERAL

PRINTED: 04/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2015
NAME OF PROVIDER OR SUPPLIER  OWENTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
(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	F 000	F000		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to provide tables at the appropriate height in the 200 Joy Dining Room for two (2) of ten (10) unsampled residents, Unsampled Resident A and Unsampled Resident B. The staff sat Unsampled Resident A and B at a table that was too high for the residents (equal to the height of their shoulders), of which they had to raise their arms to obtain food from the plate.</p> <p>The findings include:  Review of the facility's policy titled OPS200 Accommodation of Needs, dated 09/01/13, revealed the facility individualized the residents' physical environment, including the facility's common living areas, to accommodate the needs</p>	F 246	<p>Owenton Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <p>F-246</p> <ol style="list-style-type: none"> <li>The administrator and maintenance director provided an appropriate dining table on 4/29/2015 to accommodate the physical needs including with appropriate seat height for unsampled residents A and B.</li> <li>All residents of the facility have the potential to be affected The director of Nursing and Maintenance Director checked all tables in the 200 Joy room 4/8/2015 to assure they meet the appropriate table height of residents during the dining</li> </ol>		

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

TITLE

(X6) DATE

*[Signature]* Administrator 4/10/15

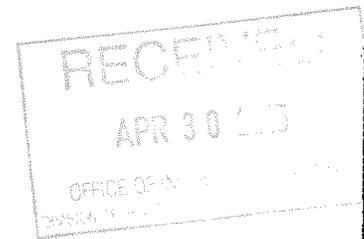
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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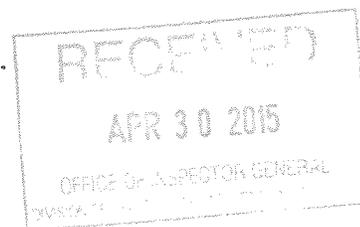
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F 246	<p>Continued From page 1</p> <p>and preferences of the individuals. The facility ensured the furniture in the common areas frequented by the residents was accommodating of physical limitations, including providing seating with appropriate seat height and positioning of tables for convenience of the residents.</p> <p>Observation of the lunch meal service, on 04/07/15 at 12:15 PM, revealed Unsampled Resident A and Unsampled Resident B were sitting and eating at a table in the 200 Joy dining room. The height of the table came to shoulder level with each of these two residents and was such that the residents had to raise their arms to head level to reach the food items on the table. The two (2) residents had each placed their plates/bowls into their laps and were eating their food from their lap.</p> <p>Observation of the lunch meal service, on 04/08/15 at 12:12 PM, revealed Unsampled Resident B was sitting at a table in the 200 Joy Room eating lunch. The resident was taking bowls of his/her food off of the table and placing them lower into his/her lap, looking inside the bowl, then replacing the bowl to the table and obtaining another bowl. The resident had to lift his/her arms in order to reach the bowls on the table. Once Unsampled Resident B decided to eat from a bowl, he/she placed it in his/her lap and ate from the bowl.</p> <p>Review of the Weights and Vitals Summary, dated 04/09/15, revealed the facility assessed Unsampled Resident A at sixty (60) inches tall. The facility assessed Unsampled Resident B at sixty-four (64) inches tall.</p> <p>Review of the Minimum Data Set (MDS), dated</p>	F 246	<p>experience. No other areas of concern were identified.</p> <p>3. Licensed Nurses and Nursing Assistants were re-educated on 4/08/2015 by the Director of Nursing to include a posttest to validate understanding of resident physical needs and dignity during dining. This test will be graded by the Assistant Director of Nursing and the Director of Nursing with a required 95% to pass. Staff not available during this time frame will be provided re-education including posttest by the Assistant Director of Nursing upon return to work.</p> <p>Monitoring of the 100 and 200 Joy rooms will be monitored daily x 2 weeks across all 3 meals, then 3x weekly x 2 weeks then weekly x 2 weeks, then as determined by the monthly Quality Improvement Committee with any corrective action if needed.</p>	



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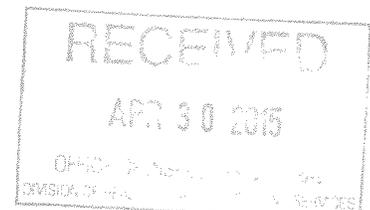
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F 246	<p>Continued From page 2</p> <p>03/06/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) evaluation and scored Unsampled Resident A at a three (3), indicating severe cognitive Impairment. The facility records further maintained diagnoses of Dementia, Hypertension, Depression, Osteoarthritis, and Osteoporosis for Unsampled Resident A. The facility assessed Unsampled Resident A as having needed to use a wheelchair.</p> <p>Review of the facility's Diet Type Report, dated 04/08/15, revealed the facility placed Unsampled Resident B was on a Dysphagia Advanced diet.</p> <p>Review of the Minimum Data Set (MDS), dated 02/27/15, revealed the facility conducted a BIMS evaluation and scored Unsampled Resident B with a three (3), indicating severe cognitive impairment. The facility records further maintained diagnoses of Heart Failure, Hypertension, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Arthritis, Osteoporosis, Dementia, and Moderate to Severe Vision Impairment for Unsampled Resident B. The facility assessed Unsampled Resident B as having needed to use a wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 04/09/15 at 2:10 PM, revealed Unsampled Resident A and Unsampled Resident B ate most of their meals at the lower table in the 200 Joy dining room because these residents were lower to the ground. The CNA stated the table may have been too high to accommodate these residents and the residents could benefit from having a lower table.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 04/07/15 at 12:30 PM, revealed Unsampled</p>	F 246	<p>4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Quality Assurance/Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.</p> <p>5. Completion Date:</p>	5/2/15



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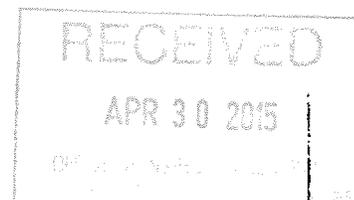
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F 246	<p>Continued From page 3</p> <p>Resident A and Unsampled Resident B ate at that specific table because the table was lower than the other tables in the 200 Joy dining room. The LPN stated the table was still tall for these two (2) residents to eat at and the residents would have benefited from sitting at an even lower table.</p> <p>Interview with the 200 Unit Manager, on 04/09/15 at 2:55 PM, revealed the facility chose to place Unsampled Resident A and Unsampled Resident B at the low table to eat because this table was the lowest table in the facility.</p> <p>Interview with the Occupational Therapist, on 04/09/15 at 2:20 PM, revealed the low table was not accommodating to the physical needs of Unsampled Resident A or Unsampled Resident B. She further revealed the facility did not adequately furnish the 200 Joy dining room with the correct table heights to accommodate the needs of the residents. Occupational Therapy consulted with the facility two (2) years ago to ensure Unsampled Resident A and Unsampled Resident B had a lower table. The Occupational Therapist observed the low table and the other tables in the 200 Joy Room and found the low table measured approximately one (1) inch shorter than the other tables in the room. The Occupational Therapist stated a table coming up to or above a resident's shoulders would indicate the table was too high for the resident. The Occupational Therapist stated a resident eating at a table that was too high was a problem because the residents may not be able to see their food. A resident may also have spilled drinks or food on themselves more often due to reaching up for items on the table.</p> <p>Interview with Speech Therapist #2, on 04/09/15</p>	F 246		



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F 246	<p>Continued From page 4</p> <p>at 2:45 PM, revealed the facility did not accommodate the dining needs of Unsampld Resident A or Unsampld Resident B in the 200 Joy dining room. The Speech Therapist stated she completed a speech evaluation on Unsampld Resident B and recommended dietary change the resident's diet to ground due to chewing difficulty and signs and symptoms of aspiration. She completed a speech evaluation on Unsampld Resident A due to dysphagia. Speech Therapist #2 stated it had been over one (1) year since she had completed an evaluation on either of these residents. Speech Therapist #2 stated a table that comes up to a resident's shoulders or eyes would not be accommodating to that resident's needs and could impede the functioning of that resident. She stated if a table was too high, causing a resident to have to reach up to obtain food, the resident would have an increased risk of spilling hot coffee on themselves or spilling food due to not being able to see what was on the table. The Speech Therapist further stated a resident with dysphagia would be at an increased risk for aspiration due to having to lift the head back to see and eat food from the table.</p> <p>Interview with the Director of Nursing (DON), on 04/09/15 at 3:30 PM, revealed the facility placed Unsampld Resident A and Unsampld Resident B at that table because it was the lowest table in the facility. The DON stated she had observed these two (2) residents eating, but had not observed them placing their plates in their laps to eat. The DON stated residents should not have to reach up for food because it could be a dignity issue as well as be tiring for the resident. The facility placing a resident at a table that was too high may keep the resident from eating an entire meal. The DON further stated the facility did not</p>	F 246			



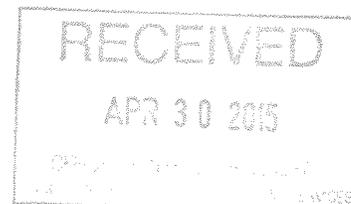
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F 246	Continued From page 5 accommodate for the physical limitations of Unsampled Resident A or Unsampled Resident B in the dining room.	F 246	F-280	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and investigations, it was determined the facility failed to review and revised the care plans for two (2) of eighteen (18) sampled residents (Residents #1 and #11). Resident #1 had six (6) falls and Resident #11 had eight (8) falls with no	F 280	1. The director of Nursing and the Unit Manager reviewed fall care plans for residents # 1 and resident # 11 for root cause to reduce the risk for falls and minimize reoccurrence on 4/10/2015. Each intervention was reviewed for effectiveness with corrective action including updating of care plan and Kardex if indicated.  2. All residents of the facility have the potential to be affected including residents that have experienced falls. A review will be completed on 4/27/2015 of residents that have experienced falls over the past 30 days by the Director of Nursing, Assistant Director of Nursing and the unit managers to assure interventions in place to reduce the risk for falls and minimize reoccurrence were	



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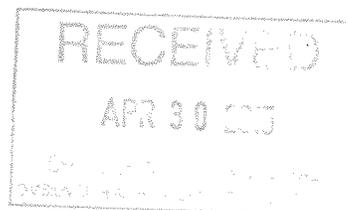
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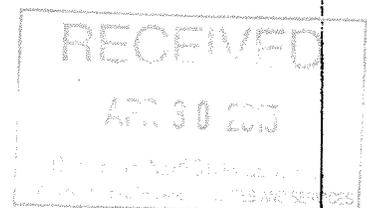
F 280	<p>Continued From page 6</p> <p>interventions added to the care plan to prevent further falls.</p> <p>The findings include:</p> <p>Review of the facility's policy for Falls, dated 05/14/14, revealed residents at risk for falls received appropriate care and the cause of falls would be investigated to reduce the risk for falls and minimize the actual occurrence of falls. A fall risk assessment would be completed and residents with scores of twelve (12) and above would be considered to have a high risk for falls. The facility would develop an individualized plan of care. If a resident fell, the facility would document the fall on a Change of Condition Note and investigate using the Fall Investigation. The care plan would be updated to reflect new interventions.</p> <p>Review of the facility's policy for Care Plans, dated 01/02/14, revealed the care plan should be revised on an ongoing basis to reflect the resident's response to care and changing needs and goals. The care plan must be customized to each individual resident's needs.</p> <p>1. Review of Resident #1's clinical record, revealed the facility admitted the resident on 06/06/12 with diagnoses of Chronic Obstructive Pulmonary Disease, Dysphagia, Congestive Heart Failure, Anxiety and Depression. The facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 01/19/15 which revealed a Brief Interview for Mental Status score of twelve (12) which meant the resident was cognitively intact; however, the resident exhibited little interest in the environment, felt down and tired. The resident required limited</p>	F 280	<p>and are still effective. There were no concerns identified.</p> <p>A review of current residents fall risk score will be done by The Director of Nursing, Assistant Director of Nursing and the unit managers on 4/30/2015. Any resident that is identified with a fall risk score of 12 or greater will have a review of diagnosis, mobility function, mental status, sensory and medications any risk identified will have care plan and Kardex revised if indicated and communicated to caregivers through re-education.</p> <p>3. Licensed nurses and nursing assistants were re- educated beginning on 4/26/2015 by the Director of Nursing with a posttest to validate understanding of supervision and fall prevention including care plan and Kardex revision if indicated. Posttest will be graded by the Assistant Director</p>	
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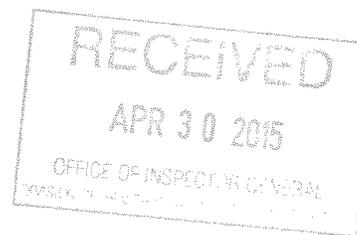
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F 280	Continued From page 7 assistance of one person for transfers and dressing, was ambulatory with a walker and was incontinent of bowel. The resident had an indwelling catheter related to urinary retention. The resident had pain daily and received antidepressants, anti-anxiety medications and hypnotics.  Further review of the clinical record for Resident #1, revealed the facility completed a Fall Risk Assessment on the resident on 01/16/15 which scored a twelve (12) and indicated the resident was a high falls risk. After a fall on 01/20/15, the facility reevaluated the resident's fall risk and determined the resident's score was twenty-four (24). This score was twice the score from 01/16/15.  Review of the Care Plan, dated 01/12/15, for Resident #1, revealed the resident's risk for falls was identified on 05/26/14. Interventions for falls included: educating the resident on the need to ask for assistance when ambulating or reaching for items; to educate the resident on safe techniques; the resident was educated on using the call light and keeping personal items within reach. Nursing staff were to assist the resident with toileting needs this was added to the care plan on 05/26/14. There were non-skid strips on the floor from the bed to the bathroom and a toileting evaluation was to be completed on 01/20/15.  Review of the Risk Management System, for 01/16/15 at 2:30 AM, revealed Resident #1 attempted to ambulate to the bathroom when the walker overturned and the resident fell. There were no injuries. The resident complained of pain; however, the facility determined the pain was not	F 280	of Nursing or Director of Nursing with a required 95% to pass. Staff not available during this time will be provided re-education including posttest by the Assistant Director of Nursing upon return to work.  Director of Nursing, Assistant Director of Nursing, or Unit Manager will review daily 5 times per week resident who has experienced a fall for intrinsic and extrinsic factors, review of current interventions, implementation of new interventions, or remove risk factors to prevent further falls including reeducation of staff and updating the care plan and Kardex if indicated. All new admissions re/admissions will also be reviewed to identify fall risk score.  4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Quality		



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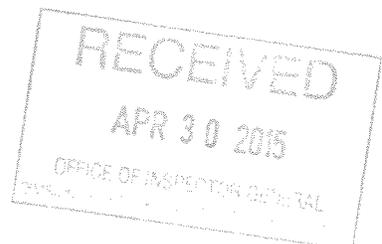
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F 280	Continued From page 8 associated with the fall. The resident had an unsteady gait, received psychotropic medications, and had a history of functional decline. The facility determined the cause of the fall to be the resident's failure to ask for assistance from staff. The preventative measure in use at the time of the fall was a low bed not listed on the care plan. After the fall, the facility updated the care plan to provide the resident with occupational therapy and physical therapy, however, the resident refused the therapy. There was no evidence the facility reviewed or revised the care plan with an intervention to immediately attempt to prevent further falls.  Review of the Risk Management System, for 01/20/15 at 2:45 AM, revealed Resident #1 attempted to ambulate to the bathroom in the room, lost their balance and fell. The resident was found on the floor by staff and no injuries were noted. The preventative measures in place were a low bed, not found on the care plan, encourage the resident to ask for assistance with toileting; keep the resident's personal items in reach; and call light in reach, added to the care plan on 05/26/14. There was a note, which stated the resident was non-compliant with asking for assistance. Contributing factors were identified as having bare feet and unsteady gait. The root cause was identified as a decline in the resident's function and non-compliance with asking for assistance. The facility determined the corrective action was to continue to redirect the resident. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.  Review of the Risk Management System, for 01/30/15 at 10:00 PM, revealed Resident #1 was	F 280	Assurance/Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.  5. Completion Date:	5/2/15	



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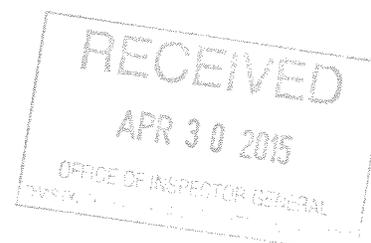
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2015
NAME OF PROVIDER OR SUPPLIER  OWENTON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
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F 280	<p>Continued From page 9</p> <p>found on the floor yelling for help. The resident replied he/she lost balance and fell to the floor in the room. There were no injuries noted. The preventative measures in place at the time of the fall were non-skid socks and the non-skid strips by the bed. The facility determined the root cause of the fall was the resident's non-compliance. The action taken to prevent further falls was to remind the resident to seek assistance. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the Risk Management System for 02/27/15 at 10:20 AM, revealed Resident #1 was found on the floor in front of the closet. The resident reported weakness developed and he/she fell. No injuries were noted. The facility determined the root cause of the fall was the resident's health and mental status. The facility's action was to request the resident to seek assistance when getting up out of bed. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the Risk Management System, for 03/14/15 at 12:00 PM, revealed Resident #1 was found on the floor in the bathroom doorway yelling for help. The resident tried to assist self to the bathroom. The preventative measures in place at the time of the fall were non-skid socks and the call light in reach. The facility determined the root cause of the fall was the resident's non-compliance with transfers and asking for assistance with ambulation. The facility's action to prevent further falls was to encourage the resident to ask for assistance. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p>	F 280		



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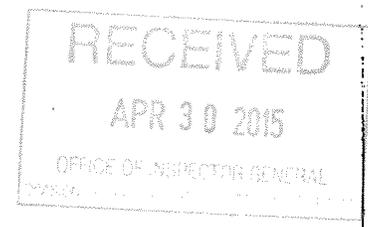
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F 280	Continued From page 10  Review of the Risk Management System, for 03/16/15 at 2:30 AM, revealed Resident #1 was found on the floor in the doorway to the bathroom. The resident indicated he/she slipped and fall going to the bathroom. The preventative measure in place at the time of the fall was a walker. There were no injuries noted. The facility determined the root cause of the fall was the resident slipped and was weak from a urinary tract infection. The facility's action to attempt to prevent further falls was to educate the resident to use the call light to ask for assistance using the bathroom, although record review revealed the resident had sustained six (6) falls and did not use the call light. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.  Review of the Kardex, dated 11/28/14, for Resident #1 revealed Resident #1 needed verbal cues to use the walker and to wear nonskid socks. The resident was independent with transfers, walking and personal hygiene; although the resident's record revealed they had sustained six (6) falls without the use of the call light or asking for assistance. The resident needed total care of one assistant to toilet.  Observation of Resident #1, on 04/07/15 at 10:25 AM, revealed the resident was in bed sleeping with the call light in reach. The resident's bed was in a low position.  Observations of Resident #1, on 04/07/15 at 11:45 AM, 2:10 PM, 3:01 PM and 3:55 PM revealed the resident was sleeping in a low bed.  Interview with Resident #1, on 04/08/15 at 8:15	F 280			



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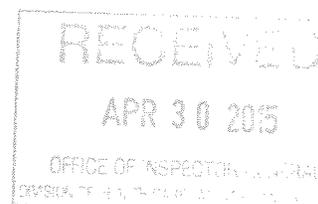
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F 280	<p>Continued From page 11</p> <p>AM, revealed the resident preferred to stay in bed most of the time. The resident was invited to activities; however, refused and stated they had no interest in most activities. The resident stated he/she would not get out of bed today. The resident stated all meals were taken in his/her room by choice. The resident stated there had been some falls related to going to the bathroom alone. He/she stated it was easier to go to the bathroom without waiting for assistance. The resident stated the desire to go to sleep and the interview was terminated.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 04/08/15 at 1:20 PM, revealed she checked her assigned residents every two (2) hours and more often at times. She stated there were no instructions on the Kardex requiring residents to be checked more frequently. She stated the Kardex contained the instructions for providing care for each resident and Resident #1 needed total care when walking to the toilet. She stated otherwise the resident was independent with care. She stated the call light was left within reach of the resident when in bed; however, the resident frequently got up alone and fell. She did not remember the resident ever being injured during a fall. She stated the resident was unsteady when walking and did need assistance to prevent falls. She stated the resident rarely used the call light even though staff provided reminders daily.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 04/08/15 at 1:40 PM, revealed the facility required staff to see every resident every two (2) hours. She stated Resident #1 was reminded to use the call light to summon assistance when going to the bathroom. She stated the resident</p>	F 280			



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F 280	<p>Continued From page 12</p> <p>was reminded daily by staff; however, the resident rarely used the call light. She stated the resident was not steady when walking. She stated the resident had never been injured during a fall. She stated the facility had provided in-service training on investigating falls and filling out the paperwork. She stated the facility continued to remind the resident to use the call light for assistance as there was little else they could do to prevent falls.</p> <p>Interview with the Unit Manager, on 04/08/15 at 3:20 PM, revealed a daily clinical meeting was held and incident reports were reviewed by nursing management to determine what occurred and what action the facility took to attempt to prevent further falls. She stated the care plan was reviewed and changed if needed by the Unit Managers to make the resident safer. She indicated interventions already in place were reinforced especially encouraging residents to ask for assistance prior to transferring independently. She stated Resident #1 would ask for assistance at times, however, the requests were inconsistent.</p> <p>2. Review of the clinical record for Resident #11, revealed the facility admitted the resident on 11/27/12 with diagnoses of Congestive Heart Failure, Hypertension, Diabetes, Depression, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the quarterly MDS, dated 01/19/15, revealed the BIMS score was a twelve (12) which meant the resident was cognitively intact. The resident had little interest in any activities and felt down. The resident required limited assistance with eating, ambulation and hygiene. The resident was able to stabilize when standing</p>	F 280			



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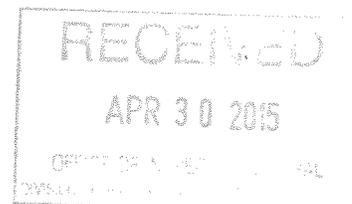
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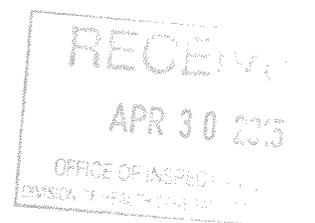
F 280	<p>Continued From page 13</p> <p>without staff assistance. The resident was continent of bowel and incontinent of bladder at times. The resident had frequent pain and received antipsychotropic medications.</p> <p>Review of the Comprehensive Care Plan, dated 05/26/14, revealed the resident had a risk for falls. The care plan interventions to prevent falls included: non-skid strips to the area in front of the bed; educate resident regarding using the call light to request assistance and leave the Dycem in the seat of the recliner; encourage resident to wear non-skid footwear; monitor blood pressure and report to physician as needed; and, encourage to wear glasses, all dated 06/18/14. Dycem to recliner, was dated 08/05/14. Educate resident regarding using the call light to request assistance and leave the Dycem in the seat of the recliner, was added again on 01/28/15. Educate resident to ask for assistance when going to the vending machine, was dated 01/30/15. In addition, the care plan problems included poor balance, inability to be independent with activities of daily living, antipsychotropic medications and smoking. The fall care plan listed falls occurring on 2/24/15, 2/25/15, 2/27/15, 3/23/15, 3/25/15, 3/26/15 and 3/30/15 with Therapy to evaluate added 03/31/15.</p> <p>Review of the Kardex, dated 11/28/14, used by the CNAs for Resident #11, revealed the resident had non-skid footwear, Dycem to the recliner seat, halo bars to assist with bed mobility and transfers, a transfer pole and a low bed against the wall.</p> <p>Review of the Risk Management System (RMS) for Resident #11, on 01/22/15 at 8:15 AM, revealed the resident was found on the floor after</p>	F 280		
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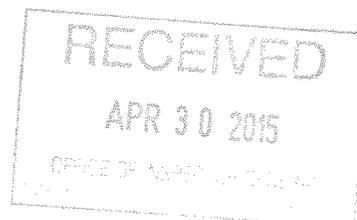
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F 280	<p>Continued From page 14</p> <p>attempting to stand. A transfer pole and non-skid strips were in place at the time of the fall. The root cause was determined to be the resident's failure to use the call light for assistance and the resident was educated to use the call light for assistance. There was no evidence the facility reviewed and revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 01/27/15 at 4:00 PM, revealed the resident was found on the floor after reaching for something while seated in a chair covered with Dycem (a nonslip material). The facility determined the root cause was the resident's health and mental status and the resident was educated to leave the Dycem in the chair. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 01/29/15 at 8:30 PM, revealed the resident was found on the floor in front of the vending machine after bending over to retrieve a purchase. The facility determined the root cause to be the resident's health and mental status and the resident was encourage to ask for assistance. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 02/27/15 at 3:05 AM, revealed the resident was found on the floor holding on to the transfer pole after slipping off the side of the bed. The bed was in low position and non-skid strips were on the floor next to the bed. The root cause was determined by the facility to be the resident's health and mental status. The facility had the resident wear non-skid footwear; however, non-skid footwear</p>	F 280			



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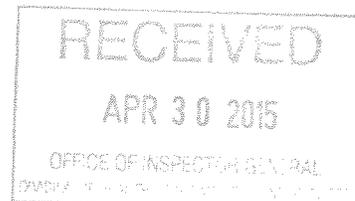
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F 280	<p>Continued From page 15</p> <p>was added to the care plan on 06/18/14. There was no evidence the facility reviewed or revised the care plan in an attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 03/14/15 at 8:20 PM, revealed the resident was walking with a walker to take a smoke break. The resident reached for the smoking apron draped over the walker and lost balance and fell. The facility determined the root cause of the fall was the smoking apron being unsecured. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 03/18/15 at 9:15 AM, revealed the resident was found on the floor after reaching for some shoes while seated in a chair. The call light and transfer pole were available. The facility determined the root cause of the fall was the resident's health and mental status and non-compliance. The facility encouraged the resident to ask for assistance. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 03/26/15 at 4:40 AM, revealed the resident was found on the floor coming from the bathroom. The facility determined the root cause of the fall was the resident's non-compliance and advised the resident to ask for assistance. There was no evidence the facility reviewed or revised the care plan to attempt to prevent further falls.</p> <p>Review of the RMS for Resident #11, on 03/30/15 at 5:45 PM, revealed the resident was found on the floor in front of the snack machine after reaching for a purchase. The facility determined</p>	F 280			



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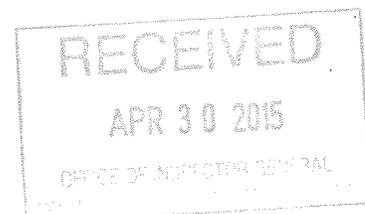
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F 280	<p>Continued From page 16</p> <p>the root cause of the fall was the resident's noncompliance and health and mental status. An Occupational Therapy evaluation was requested; however, there was no evidence the facility reviewed or revised the care plan to immediately attempt to prevent further falls.</p> <p>Observation of Resident #11, on 04/07/15 at 2:10 PM, revealed the resident was seated in a wheelchair next to the bed without shoes or non-skid footwear. Piles of belongings were noted around the room. The area under the resident's bed was full of plastic bags, shoes, clothing and other items. There were several pairs of shoes and some clothing on the floor next to the bed and by the bedside table with personal items on the floor next to the bathroom doorway.</p> <p>Observation of Resident #11, on 04/08/15 at 11:15 AM, revealed the resident was up in the room without any footwear and not using the walker. The resident stood in the doorway to the hall while staff walked by without taking any action to redirect the resident.</p> <p>Interview with CNA #5, on 04/08/15 at 12:46 PM, revealed Resident #11 was non-compliant with care and did not use the call light to ask for assistance of staff. She stated the resident continuously removed the non-skid socks and shoes. She stated the resident was not able to use the transfer pole when getting up from bed due to weakness. She revealed the resident had a rolling walker that the resident did not use due to forgetfulness. She indicated the residents were checked every two (2) hours and that was the training she had received from the facility. She stated a fall could result in an injury to the</p>	F 280			



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F 280	<p>Continued From page 17 resident.</p> <p>Interview with CNA #4, on 04/08/15 at 1:10 PM, revealed she cared for Resident #11 frequently and the resident fell often. She stated the resident would be walking with the walker and just walk off and leave the walker. She indicated the resident would take off the non-skid socks or shoes and slip and fall. She stated the facility trained staff to check residents every two (2) hours for hygiene and to make sure they were all right. She stated falling could cause an injury.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 04/08/15 at 3:10 PM, revealed Resident #11 used a transfer pole to assist with getting out of bed and walking around the bed. She stated the resident was stubborn and did not like anyone to assist with care. She stated the resident was incontinent at night and wore an adult brief at all times in case of emergency. She stated the resident's room was right across from the nursing station and was checked by staff every two (2) hours. She stated the resident did as the resident pleased. She stated the resident hoarded and there was often clutter in the room on the floors. She indicated the resident would not use the call light. She stated she did not have any responsibility for the resident's care plan. She stated the resident had no injuries; however, falling could cause an injury.</p> <p>Interview with the Unit Manager, on 04/08/15 at 3:20 PM, revealed Resident #11 was inconsistent in requesting assistance from staff. She stated the Director of Nursing, the Unit Managers met every She business day in the morning and all falls were reviewed. She stated the fall reports were reviewed to determine what happened to</p>	F 280			



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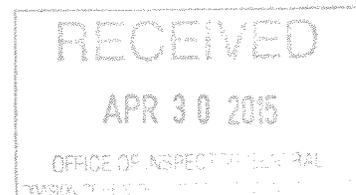
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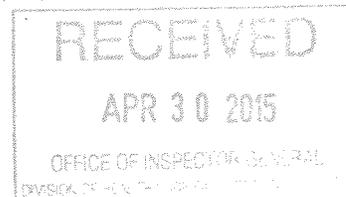
F 280	<p>Continued From page 18</p> <p>cause the fall and why. She indicated the care plan for the resident was reviewed and changes were made to make the resident safer and often those changes were to reinforce interventions already in place to prevent falls. She stated the care plan was not evaluated, but added to.</p> <p>Interview with the Minimum Data Set (MDS) Registered Nurse (RN), on 04/09/15 at 2:10 PM, revealed all incident reports were reviewed the next business day by the Director of Nursing, Unit Managers and MDS RN. She stated the clinical meeting every morning reviewed falls and discussed them daily. She stated she did attend the meeting as did the Unit Managers. She stated the Unit Managers updated the care plan after a resident's fall. She indicated reusing interventions was practiced in the facility, so reemphasizing verbal cues or instructions was a common practice. She revealed the care plan interventions were not working and the resident continued to fall. She was unable to provide more information.</p> <p>Additional interview with the MDS Coordinator, on 04/09/15 at 3:40 PM, revealed she was responsible for the comprehensive care plan. She stated she did not update the care plans on a daily basis unless an MDS was completed. She stated the Unit Manager was responsible for updating care plans on a daily basis. She stated all residents were checked every two (2) hours. She stated Resident #11's care plan was not working to prevent falls.</p> <p>Interview with the Director of Nursing, on 04/09/15 at 2:10 PM, revealed the Unit Managers were trained by the facility to update care plans when a resident fell. She stated a clinical</p>	F 280		
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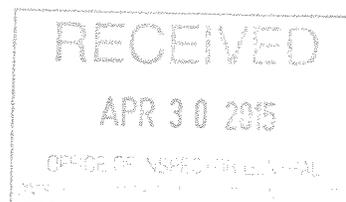
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F 280	Continued From page 19 meeting was held each business day and falls were reviewed to determine if the fall report was complete and to add to the care plan if needed. She stated the cause of falls was determined by the facility and involved what happened to the resident. She stated the care plan for Resident #11 was not preventing the resident from falling.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  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 follow the comprehensive care plan for one (1) of eighteen (18) sampled residents and nine (9) of ten (10) unsampled residents, (Resident #4 and Unsampled Residents A, C, D, E, F, G, H, I and J). The facility staff left the residents, who they assessed as needing monitoring during meals due to the risk of aspiration, unattended in the dining room.  The findings include:  Review of the facility's policy regarding Care Plans, dated 01/02/14, revealed the purpose of the comprehensive care plan for each resident was to provide necessary physical, mental and psychosocial care to residents to maintain their well-being.	F 282	F-282  1. Resident # 4 of sampled residents care plan was reviewed by the Director of Nursing and unit manager and updated if indicated on 4/8/2015 to include the risk involved of being left unattended/unsupervised in the 200 Joy room. Unsampled Residents A, C, D, E, F, G, H, I and J care plans were reviewed by the Director of Nursing and unit manager and updated if indicated on 4/8/2015 to include the risk of being left unattended/unsupervised in the 200 Joy room. Involved nursing staff was reeducated regarding supervision and		



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NAME OF PROVIDER OR SUPPLIER  OWENTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
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F 282	Continued From page 20  Observation of the 200 Joy Dining Room, on 04/08/15 from 8:25 AM - 8:39 AM, revealed fourteen (14) residents in the dining room with no staff present and trays of food in front of the twelve (12) residents. Ten (10) of the twelve (12) residents with food were physician ordered to be on dysphagia diets; Resident #4 and Unsampld Residents A, C, D, E, F, G, H, I and J.  Review of the facility's Diet Type report, dated 04/08/15, revealed Resident #4 and Unsampld Residents A, C, D, E, F, G, H, I and J were all ordered dysphagia diets.  Review of the physician orders revealed Resident #4 had a diagnosis of dysphagia (difficulty swallowing) and was ordered a dysphagia pureed diet, dated 02/27/15. Unsampld Resident A had an order for a dysphagia diet, dated 10/01/14. Unsampld Resident C had an order for a dysphagia diet, dated 04/02/15. Unsampld Resident D had an order for a dysphagia diet, dated 0/17/14. Unsampld Resident E had an order for a dysphagia diet, dated 07/26/14. Unsampld Resident F had an order for a dysphagia diet, dated 04/03/15. Unsampld Resident G had an order for a dysphagia diet, dated 02/27/15. Unsampld Resident H had an order for a dysphagia diet, dated 11/26/14. Unsampld Resident I, had an order for a dysphagia diet, dated 12/02/14. Unsampld Resident J had an order for a dysphagia diet, dated 07/31/14.  Review of the comprehensive care plan, dated 10/11/14, revealed Resident #4 was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.	F 282	services by qualified staff as determined by the care plan. This re-education was completed by the Director of Nursing on 4/8/2015 upon discovery with a posttest to validate understanding. Posttest was graded by the Director of Nursing with a required 95% to pass.  2. All residents of the facility have the potential to be affected residents that require supervision and assistance during meals due to risk of aspiration review will be completed 4/29/2015 by the Director of Nursing, Assistant Director of Nursing, and/or Unit Manger of current residents' including residents on speech therapy caseload to determine residents that may be at risk or require supervision with dining. There were no concerns identified. All new admissions/re-admissions will be reviewed by		



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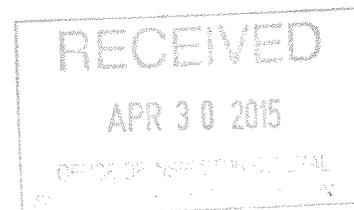
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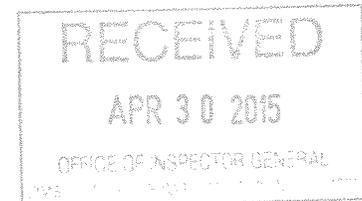
F 282	<p>Continued From page 21</p> <p>Review of the comprehensive care plan, dated 07/29/14, revealed Unsampld Resident A, was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 04/11/14, revealed Unsampld Resident C was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 09/15/14, revealed Unsampld Resident D was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 05/08/14 for Unsampld Resident E was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 01/29/15, revealed Unsampld Resident F was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 06/14/11 revealed Unsampld Resident G was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 11/10/14, revealed Unsampld Resident H was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 11/14/11, revealed Unsampld Resident I was to be monitored for signs/symptoms of aspiration</p>	F 282	<p>the Director of Nursing, Assistant Director of Nursing and unit managers to identify any risk or supervision needs with dining with corrective action if indicated.</p> <p>3. Licensed Nurses, Nursing Assistants and Speech Therapy were re-educated on 4/8/2015 upon discovery with a posttest to validate understanding of need to provide adequate supervision and assistance for residents at high risk for aspiration during mealtime as determined by the resident care plan. The posttest was graded by the Director of Nursing with a required 95% to pass. Department Mangers will be re/educated on 4/15/15 with a posttest to validate understanding with a required 95% to pass. The posttest was graded by the Director of Nursing with a required 95% to pass. RNS, LPNS and CNAS that were not</p>	
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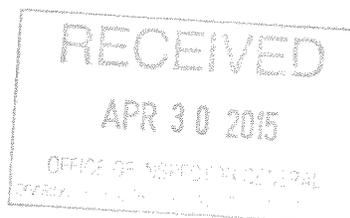
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F 282	<p>Continued From page 22 due to the diagnosis of dysphagia.</p> <p>Review of the comprehensive care plan, dated 05/05/14 revealed Unsampled Resident J was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 04/09/15 at 5:40 PM, revealed she was aware Resident #4 and most of the other residents who ate in the 200 Joy Dining Room were a swallow risk which meant staff should be in the dining room when those residents were eating. She stated she was assigned to the 200 Joy Dining Room on 04/08/15 at the breakfast meal and she left the room to answer a call light, but she was not aware all of the other staff had also left the room. She indicated the residents who needed to have staff stay with them at mealtimes was listed on the CNA care plans.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 04/09/15 at 5:45 PM, revealed she was the nurse assigned to the 200 Joy Dining Room for the breakfast meal on 04/08/15. She stated a nurse was always assigned to the 200 Joy Dining Room for all meals due to the high risk of aspiration for the residents who ate their meals there. She stated the information about the high risk of aspiration was listed on the residents' comprehensive care plans and leaving the residents unattended indicated she was not following the residents' care plans. LPN #7 revealed she left the 200 Joy Dining Room on 04/08/15 to start her medication pass even though some of the residents had not finished eating and had their meal trays available. She further stated it was a standard of practice to follow the residents' comprehensive care plans</p>	F 282	<p>available during this time will be re/educated upon return to work with a posttest to validate understanding.</p> <p>The Director of Nurses, Assistant Director of Nurses or Unit Manager will observe residents determined to be at risk for aspiration across all meals to ensure adequate supervision and assistance as careplanned is provided daily times 2 weeks then 3 times per week times 2 weeks then as determined by the monthly Quality Assurance/Performance Improvement Committee with corrective action if indicated upon discovery.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Quality Assurance/Performance</p>		



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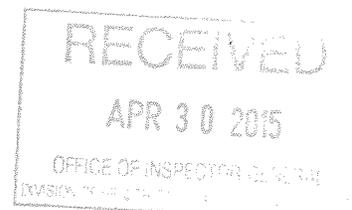
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F 282	Continued From page 23 and residents could be harmed if they choked or aspirated their food.  Interview with the Director of Nursing (DON), on 04/09/15 at 5:50 PM, revealed any resident who was at risk of aspiration during a mealtime should be watched by staff. She stated the comprehensive care plans for the residents who ate in the 200 Joy Dining Room did indicate those who were at high risk for aspiration and the staff were not following their care plans when they left the residents unattended during a mealtime. The DON revealed it was a standard of nursing practice for her staff to follow the residents' comprehensive care plans and they were trained to follow the residents' care plans. She stated it was the responsibility of the Unit Managers to monitor the staff regarding following residents' care plans, but that monitoring was not documented as to how well the care plans were followed.	F 282	Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.  5. Completion Date:	5/2/15	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide adequate	F 323	1. The Director of Nursing and the Unit Manager reviewed fall care plans for residents #1, and # 11 for current intervention and new interventions to decrease the risk of falls for this resident and reviewed the care plan for resident # 4 on 4/8/2015 and up-dated to determine the risk involved of being left unattended/unsupervised in the 200 Joy room.		



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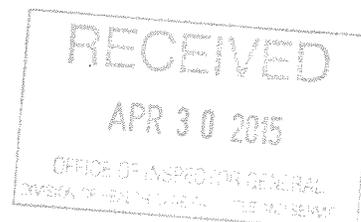
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F 323	Continued From page 24 supervision to prevent accidents based on assessed resident needs for three (3) of eighteen (18) Sampled Residents and nine (9) of ten (10) Unsamped Residents, Resident #1, #4 and #11 and Unsamped Residents A, C, D, E, F, G, H, I and J. Resident #1 and Resident #11 had multiple falls and Resident #4 and Unsamped Residents A, C, D, E, F, G, H, I and J, assessed by the facility as at risk for aspiration, and staff left them unattended during a meal.  The findings include:  Review of the facility's policy regarding Accidents, Incidents, and Adverse Events, dated 09/01/13, revealed the purpose of the policy was to provide a safe and healthful environment for residents, visitors, and staff.  Review of the facility's policy for Falls Management, dated 05/15/14, revealed residents were assessed for falls as part of the nursing assessment process. Those determined to be at risk for falls would receive appropriate interventions to reduce the risk and minimize injury. An individualized care plan would be developed and reviewed and revised regularly. An investigation would be conducted using the Fall Investigation/QA and other appropriate tools in Risk Management Systems.  Observation of the 200 Joy Dining Room, on 04/08/15 from 8:25 AM - 8:39 AM, revealed fourteen (14) residents in the dining room with no staff present and trays of food in front of twelve (12) of them. Ten (10) of the twelve (12) residents with food were physician ordered to be on dysphagia diets, Resident #4 and Unsamped Residents A, C, D, E, F, G, H, I and J,	F 323	Unsamped Residents A, C, D, E, F, G, H, I and J care plans were reviewed by the Director of Nursing, Assistant Director of Nursing and unit manager's on 4/8/2015 to determine risk of being left unattended/unsupervised in the 200 Joy room during mealtime. Staff was reeducated regarding supervision and services by qualified staff as determined by the care plan. This re-education was completed by the Director of Nursing on 4/8/2015 upon discovery and a posttest was given to validate understanding with a required 95% to pass. Test will be graded by the Director of Nursing or Assistant Director of Nursing,  2. All residents of the facility have the potential to be affected including residents that have experienced falls and residents that require supervision and assistance during meals due to	



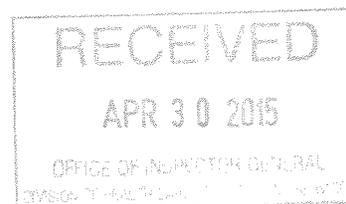
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F 323	Continued From page 25  Review of Resident #4's clinical record revealed the facility admitted the resident on 12/01/14 with diagnoses to include Alzheimer's Dementia and Aftercare Lower Leg Fracture. The facility assessed Resident #4 on 01/16/15 with a Brief Interview for Mental Status (BIMS) score of a three (3) indicating a severe cognitive loss. Review of the physician orders, dated 02/27/15, revealed Resident #4 had a diagnosis of dysphagia (difficulty swallowing) and was ordered a dysphagia pureed diet. Review of Resident #4's comprehensive care plan, dated 12/11/14, revealed the resident was to be monitored for signs/symptoms of choking and/or aspiration (entry of food into the lungs).  Review of a facility Diet Type report, dated 04/08/15, revealed Resident #4 and Unsampled Residents A, C, D, E, F, G, H, I and J were all ordered dysphagia diets.  Review of physician orders for Unsampled Resident A, dated 10/01/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 07/29/14, revealed Unsampled Resident A, was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.  Review of physician orders for Unsampled Resident C, dated 04/02/15, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 04/11/14, revealed Unsampled Resident C was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.  Review of physician orders for Unsampled	F 323	risk of aspiration A review will be completed on 4/27/2015 of residents that have experienced falls over the past 30 days by Director of Nursing, Assistant Director of Nursing and Unit Manager to assure Interventions in place to reduce the risk for falls and minimize reoccurrence were and are still effective. There were no concerns identified.  A review of current residents fall risk score will be done by the Director of Nursing, Assistant Director of Nursing and unit managers on 4/30/2015. Any resident that is identified with a fall risk score of 12 or greater will have a review of diagnosis, mobility function, mental status, sensory and medications any risk identified will have care plan and Kardex revised if indicated and communicated to caregivers through re-education.	



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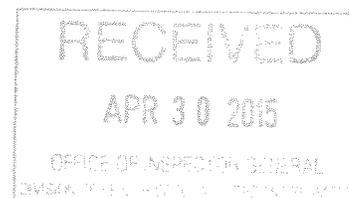
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F 323	<p>Continued From page 26</p> <p>Resident D, dated 07/17/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 09/15/14, revealed Unsampled Resident D was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of physician orders for Unsampled Resident E, dated 07/26/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 05/08/14 for Unsampled Resident E was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of physician orders for Unsampled Resident F, dated 04/03/15, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 05/08/14 for Unsampled Resident E was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of physician orders for Unsampled Resident G, dated 02/27/15, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 06/14/11 revealed Unsampled Resident G was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p> <p>Review of physician orders for Unsampled Resident H, dated 11/26/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 11/10/14, revealed Unsampled Resident H was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.</p>	F 323	<p>A review will be completed on 4/30/2015 by the Director of Nursing, Assistant Director of Nursing, and/or Unit Manger of current residents' including residents on speech therapy caseload to determine residents that may be at risk or require supervision with dining. There were no concerns identified. All new admissions/re-admissions will be reviewed the Director of Nursing, Assistant Director of Nursing and unit managers to identify any risk or supervision needs with dining with corrective action if indicated.</p> <p>3. Licensed nurses and nursing assistants were re- educated beginning on 4/26/2015 by the Director of Nursing with a posttest to validate understanding of supervision and fall prevention including care plan and Kardex revision if indicated. Posttest will be</p>	



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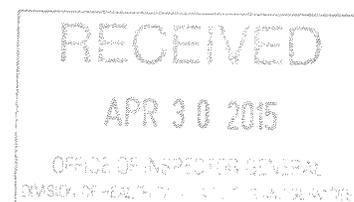
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F 323	Continued From page 27 Review of physician orders for Unsampled Resident I, dated 12/02/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 11/14/11, revealed Unsampled Resident I was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.  Review of physician orders for Unsampled Resident J, dated 07/31/14, revealed an order for a dysphagia diet. Review of the comprehensive care plan, dated 05/05/14 revealed Unsampled Resident J was to be monitored for signs/symptoms of aspiration due to the diagnosis of dysphagia.  Interview with Certified Nursing Assistant (CNA) #4, on 04/08/15 at 9:10 AM, revealed she was assigned to the 200 Joy Dining Room for the breakfast meal that day and two staff were in the room when she left to answer a call light. She stated it was her understanding at least one staff was to be in the 200 Joy Dining Room at all times due to the choking risk for most of the residents who dined there.  Interview with the 200 Unit Manager, on 04/08/15 at 9:23 AM, revealed staff were supposed to be in the 200 Joy Dining Room at all times due to the choking/aspiration risk of the residents who dined there. She indicated most of the residents who ate in that dining room were diagnosed with dysphagia and were at risk of choking and/or aspirating their food.  Interview with the Director of Nursing (DON), on 04/09/15 at 9:00 AM, revealed she assigned a nurse and two (2) CNA's to the 200 Joy Dining	F 323	graded by the Assistant Director of Nursing or Director of Nursing with a required 95% to pass. Staff not available during this time will be provided re-education including posttest by the Assistant Director of Nursing upon return to work. Licensed Nurses, Nursing Assistants and Speech Therapy were re-educated on 4/8/2015 upon discovery with a posttest to validate understanding of need to provide adequate supervision and assistance for residents at high risk for aspiration during mealtime as determined by the resident care plan. The posttest was graded by the Director of Nursing with a required 95% to pass. Department Mangers will be re/educated on 4/15/15 with a posttest to validate understanding with a required 95% to pass. The posttest was graded by the Director of Nursing with a required 95% to pass. RNS, LPNS and CNAS that		



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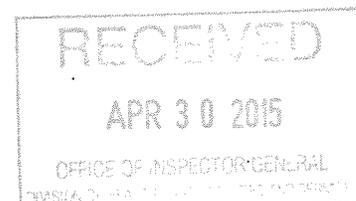
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2015
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F 323	<p>Continued From page 28</p> <p>Room for every meal due to the high risk of choking/aspiration of the residents who ate in that dining room. She indicated staff were trained to stay in that dining room with the residents because they were at high risk of choking/aspiration. However, the staff were in the process of taking some residents back to their rooms after the meal, on 04/08/15 at 8:25 AM, and did not make sure at least one staff was in the room at all times. The DON indicated a resident left alone in that dining room could have choked and/or aspirated on their food and could have been harmed. The DON stated the Unit Managers were responsible to monitor the dining rooms for staff presence as assigned and when the 200 Unit Manager identified no staff in the room on 04/08/15 the problem was corrected immediately. The DON stated she did random monitoring of the dining rooms, but that monitoring was not documented.</p> <p>Review of the facility's policy for Falls Management, dated 06/15/14, revealed residents were assessed for falls as part of the nursing assessment process. Those determined to be at risk for falls would receive appropriate interventions to reduce risk and minimize injury. An investigation would be conducted using the Fall Investigation/QA and other appropriate tools in the Risk Management Systems.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident on 11/27/12, with diagnoses of Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, and Depression.</p>	F 323	<p>were not available during this time will be reeducated upon return to work with a posttest to validate understanding.</p> <p>The Director of Nurses, Assistant Director of Nurses or Unit Manager will review daily 5 times per week any resident who has experienced a fall for intrinsic and extrinsic factors, review of current interventions, implementation of new interventions, or remove risk factors to prevent further falls including reeducation of nursing staff and updating the care plan and Kardex if indicated. All new admissions re/admissions will also be reviewed to identify fall risk score.</p> <p>The Director of Nurses, Assistant Director of Nurses or Unit Manager will observe residents determined to be at risk for aspiration across all</p>		



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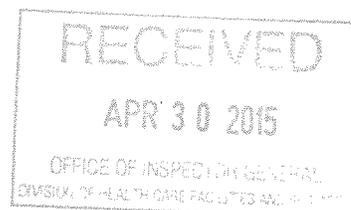
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F 323	<p>Continued From page 29</p> <p>Review of the quarterly MDS assessment completed by the facility for Resident #1, on 01/07/15, revealed a Brief Interview for Mental Status score of twelve (12) which meant the resident was cognitively intact. The resident required limited assistance with transfers and dressing, and supervision when using the walker. The resident was frequently incontinent of bladder and wore briefs at all times. The resident received antidepressant and anti-anxiety medications. The resident exhibited little interest in the environment and was tired. The resident was assessed as having no recent behaviors or falls.</p> <p>Review of the Comprehensive Plan of Care, dated 01/12/15, for Resident #1, revealed the resident had a care plan for falls. The care plan included: non-skid floor strips; assess for changes in status; dycem to chair; educate resident to ask for assistance when going to the vending machine; educate resident on use of the call light and to leave dycem in the recliner; encourage to use non-skid footwear; encourage to ask for assistance; monitor for orthostatic hypotension; Occupational Therapy evaluation; place dycem in chair; glasses; ask for assistance; replace non-skid strips; call light; give verbal cues for safety; and, a low bed.</p> <p>Review of the Risk Management System for Resident #1 revealed the resident sustained falls on 01/18/15 at 2:30 AM; 01/20/15 at 2:45 AM; 01/30/15 at 10:00 PM; 02/07/15 at 10:20 AM; 03/14/15 at 12:00 PM; and, 03/16/15 at 2:30 AM. On 01/16/15 the resident was taking self to the bathroom when the walker overturned and the resident fell. On 01/20/15 the resident was taking self to the bathroom and lost their balance and</p>	F 323	<p>meals to ensure adequate supervision and assistance as careplanned is provided daily times 2 weeks then 3 times per week times 2 weeks then as determined by the monthly Quality Assurance/Performance Improvement Committee with corrective action if indicated upon discovery.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Quality Assurance/Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.</p>		



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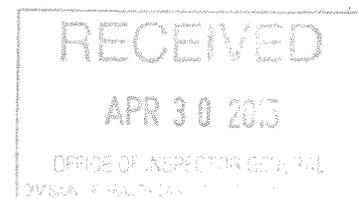
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F 323	<p>Continued From page 30</p> <p>fell. On 01/30/15 the resident was found on the floor yelling for help. On 02/27/15 the resident was found on the floor in front of the closet. On 03/14/15 the resident was found on the floor in the bathroom doorway yelling for help. On 03/16/15 the resident was found on the floor in the doorway to the bathroom. There were no staff present during any of these falls. The facility determined the cause of the falls to be the resident's failure to ask for assistance from staff; however, there was no evidence the facility identified the root cause of the falls and implement interventions based on the resident's assessed needs and the causative factors to include supervision. There was no evidence the facility determined the cause of the fall or evaluated the effectiveness of the care plan interventions to determine if the resident required more frequent checks than every two hours.</p> <p>Review of the Kardex, dated 11/28/14, for Resident #1, revealed Resident #1 needed verbal cues to use the walker and to wear nonskid socks. The resident was independent with transfers and walking and personal hygiene. Although record review revealed the resident sustained six (6) falls taking self to the bathroom or going to the closet. The resident required total care of one assistant to toilet.</p> <p>Observation of Resident #1, on 04/07/15 at 10:25 AM, revealed the resident was in bed sleeping with the call light in reach. The resident's bed was in a low position.</p> <p>Observations of Resident #1 on 04/07/15 at 11:45 AM, 2:10 PM, 3:01 PM and 3:55 PM revealed the resident was sleeping in bed.</p>	F 323	5. Completion Date:	5/2/15	



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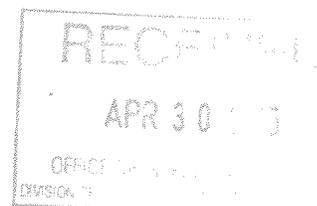
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F 323	Continued From page 31  Interview with Resident #1, on 04/08/15 at 8:15 AM, revealed the resident preferred to stay in bed most of the time. The resident was invited to activities and refused and expressed no interest in most activities. The resident stated he/she would not get out of bed today. The resident stated that all meals were taken in his/her room by choice. The resident further stated there had been some falls related to going to the bathroom alone. The resident then stated the desire to go to sleep and the interview was terminated.  Interview with Certified Nurse Aide (CNA) #4, on 04/08/15 at 1:20 PM, revealed she checked her assigned residents every two (2) hours and more often at times. She stated there were no instructions on the Kardex requiring residents to be checked more frequently. She stated the Kardex contained the instructions for providing care for each resident and Resident #1 needed total care when walking to the toilet. She stated otherwise the resident was independent with care. She stated the call light was left within reach of the resident when in bed; however, the resident frequently got up alone and fell. She did not remember the resident ever being injured during a fall. She stated the resident was unsteady when walking and did need assistance to prevent falls. She stated the resident rarely used the call light even though staff provided reminders daily.  Interview with Licensed Practical Nurse (LPN) #5, on 04/08/15 at 1:40 PM, revealed the facility required the staff to see every resident every two (2) hours. She stated Resident #1 was reminded to use the call light to summon assistance when going to the bathroom. She stated the resident	F 323			



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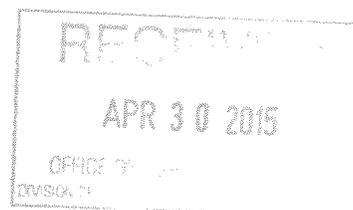
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F 323	<p>Continued From page 32</p> <p>was reminded daily by staff, however, the resident rarely used the call light. She revealed the resident was not steady when walking and frequently fell. She stated the resident had never been injured during a fall. She stated the facility had provided in-service training on investigating falls and filling out the paperwork. She stated the facility continued to remind the resident to use the call light for assistance as there was little else they could do to prevent falls.</p> <p>Interview with the Unit Manager, on 04/08/15 at 3:20 PM, revealed a daily clinical meeting was held and incident reports were reviewed by nursing management to determine what occurred and what action the facility took to attempt to prevent further falls. She stated the care plan was reviewed and changed if needed by the unit managers to make the resident safer. She indicated interventions already in place were reinforced especially encouraging residents to ask for assistance prior to transferring independently. She stated Resident #1 would ask for assistance at times, however, the requests were inconsistent. She stated she had received training on determining the cause of falls and care planning.</p> <p>Interview with the Minimum Data Set (MDS) Registered Nurse (RN), on 04/09/15 at 2:10 PM, revealed the care plan interventions were not working for Resident #1 as the resident continues to fall.</p> <p>3. Review of the clinical record for Resident #11, revealed the facility admitted the resident on 11/27/12 with diagnoses of Congestive Heart Failure, Hypertension, Diabetes, Depression, and</p>	F 323			



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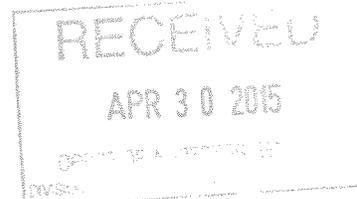
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F 323	<p>Continued From page 33</p> <p>Chronic Obstructive Pulmonary Disease.</p> <p>Review of the quarterly MDS, dated 01/19/15, revealed a BIMS score of twelve (12) which meant the resident was cognitively intact. The resident had little interest in any activities and felt down. The resident required limited assistance with eating, ambulation and hygiene. The resident was able to stabilize when standing without staff assistance. The resident was continent of bowel and incontinent of bladder at times. The resident had frequent pain and received antipsychotropic medications.</p> <p>Review of the Comprehensive Care Plan, dated 05/26/14, revealed the resident had a risk for falls. The care plan interventions to prevent falls included: non-skid strips to the area in front of the bed; dycem to the recliner; educate resident to ask for assistance when going to the vending machine; educate resident regarding using the call light to request assistance; to leave the dycem in the seat of the recliner; encourage resident to wear non-skid footwear; Therapy to evaluate; monitor blood pressure and report to physician as needed; and, encourage to wear glasses.</p> <p>Review of the Kardex, dated 11/28/14, used by the CNAs, for Resident #11, revealed the resident had non-skid footwear, dycem to the recliner seat, halo bars to assist with bed mobility and transfers, a transfer pole and a low bed against the wall.</p> <p>Review of the Risk Management System (RMS)</p>	F 323			



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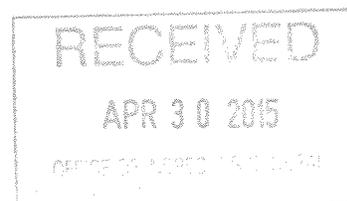
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F 323	Continued From page 34 for Resident #11 revealed the resident sustained falls on 01/22/15 at 8:15 AM, on 01/27/15 at 4:00 PM, on 01/29/15 at 8:30 AM, on 02/27/15 at 3:05 AM; on 03/14/15 at 8:20 PM; on 03/18/15 at 9:15 AM; on 03/26/15 at 4:40 AM; and on 03/30/15 at 5:45 PM. On 01/22/15 the resident was found on the floor after attempting to stand. On 01/27/15 the resident was found on the floor after reaching for something while seated in a chair covered with dycem (a nonslip material). On 01/29/15 the resident was found on the floor in front of the vending machine after bending over to retrieve a purchase. On 02/27/15 the resident was found on the floor holding on to the transfer pole after slipping off the side of the bed. On 03/14/15 the resident was walking with a walker to take a smoke break. The resident reached for the smoking apron draped over the walker and lost their balance and fell. On 03/18/15 the resident was found on the floor after reaching for some shoes while seated in a chair. On 03/26/15 the resident was found on the floor coming from the bathroom. On 03/30/15 the resident was found on the floor in front of the snack machine after reaching for a purchase. The root cause was determined to be the resident's failure to use the call light for assistance or ask staff for assistance. There were no staff present during these falls. There was no evidence the facility identified the root cause of the falls or determined if additional supervision besides the every two hour checks would be appropriate for the resident based on the resident's assessed needs.  Observation of Resident #11, on 04/07/15 at 2:10 PM, revealed the resident was seated in a wheelchair next to the bed without shoes or non-skid footwear. Piles of belongings were noted around the room. The area under the	F 323			



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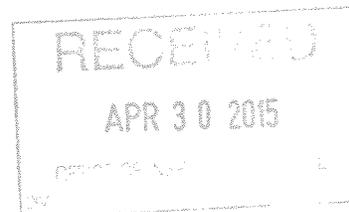
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F 323	<p>Continued From page 35</p> <p>resident's bed was full of plastic bags, shoes, clothing and other items. There were several pairs of shoes and some clothing on the floor next to the bed and by the bedside table with personal items on the floor next to the bathroom doorway.</p> <p>Observation of Resident #11, on 04/08/15 at 11:15 AM, revealed the resident was up in the room without any footwear and not using the walker. The resident stood in the doorway to the hall while staff walked by without taking any action to redirect the resident.</p> <p>Interview with CNA #5, on 04/08/15 at 12:46 PM, revealed Resident #11 was non-compliant with care and did not use the call light to ask for assistance of staff. She stated the resident continuously removed the non-skid socks and shoes. She stated the resident was not able to use the transfer pole when getting up from bed due to weakness. She revealed the resident had a rolling walker that the resident would forget to use due to forgetfulness. She indicated the residents were checked every two (2) hours and that was the training she had received from the facility. She stated a fall could result in an injury to the resident.</p> <p>Interview with CNA #4, on 04/08/15 at 1:10 PM, revealed she cared for Resident #11 frequently and the resident fell often. She indicated the resident would forget the walker and/or take off the non-skid socks or shoes and slip and fall. She stated the facility trained staff to check residents every two (2) hours for hygiene and to make sure they were alright. She stated falling could cause an injury.</p>	F 323			



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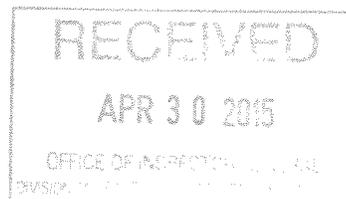
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F 323	<p>Continued From page 36</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 04/08/15 at 3:10 PM, revealed Resident #11 used a transfer pole to assist with getting out of bed and walking around the bed. She stated the resident was stubborn and did not like anyone to assist with care. She stated the resident was mostly incontinent at night and wore an adult brief at all times in case of emergency. She stated the resident's room was right across from the nursing station and was checked by staff every two (2) hours. She stated the resident did as the resident pleased. She stated the resident hoarded and there was often clutter in the room on the floors. She indicated the resident would not use the call light. She stated the resident had no injuries; however, falling could cause an injury.</p> <p>Interview with the Unit Manager, on 04/08/15 at 3:20 PM, revealed Resident #11 was inconsistent in requesting assistance from staff. She stated the Director of Nursing and the Unit Managers met every business day in the morning and all falls were reviewed. She stated the fall reports were reviewed to determine what happened to cause the fall and why. She stated she was educated on completion of the falls report and determining the cause of falls.</p> <p>Continued interview with the MDS RN, on 04/09/15 at 2:10 PM, revealed all incident reports were reviewed the next business day by the Director of Nursing, Unit Managers and MDS RN. She stated the clinical meeting every morning reviewed falls and discussed them daily. She stated she did attend the meeting as did the Unit Managers. She stated there were no interventions for resident supervision.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 323		



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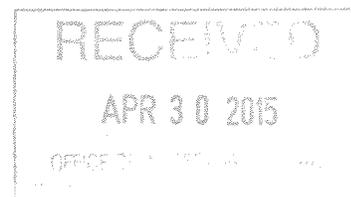
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F 323	Continued From page 37 04/09/15 at 2:10 PM, revealed She stated a clinical meeting was held each business day and falls were reviewed to determine if the fall report was complete. She stated each fall was reviewed to determine the cause of what happened, who was involved and why something happened. Continued interview with the DON, on 04/09/15 at 2:36 PM, revealed she had not thought to have residents supervised more frequently than every two hours. She stated there were no interventions on the care plans for supervision of the resident. She stated the care plan for Resident #1 did not work and the residents have continued to fall.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F-441  1. Re-education regarding the Hand washing policy and procedure was provided to Certified Nursing Assistant # 4 upon discovery 4/8/2015 by Assistant Director of Nursing with a posttest to validate understanding, with a required 95% to pass. Posttest will be graded by the Assistant Director of Nursing and/or the Director of Nursing. Unsampled residents #A, B, C, and D did not experience any negative outcome.		



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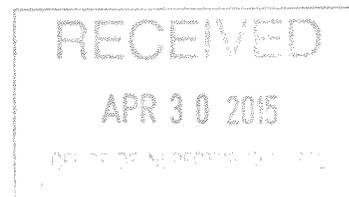
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F 441	<p>Continued From page 38</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility 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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy for Handwashing, it was determined the facility failed to ensure one (1) of three (3) nursing staff serving food in the Joy Dining Room followed handwashing procedures. Certified Nurse Aide (CNA) #4 was observed to go from resident to resident (Unsampled Residents A, B, C, and D) during the meal service without sanitizing hands.</p> <p>The findings include: Review of the facility's policy for Handwashing, dated 10/01/13, revealed handwashing reduced the transmission of pathogenic microorganisms. Handwashing or sanitizing was completed before any direct contact with a resident, after contact with inanimate objects in the immediate vicinity of a resident, and before and after assisting</p>	F 441	<p>2. All residents of the facility have the potential to be affected. The Director of Nurses, Assistant Director of Nursing observed handwashing performed by staff during meal service on 4/30/2015 with corrective action if indicated.</p> <p>3. All staff including Licensed Nurses and Nursing Assistants will be re-educated on Hand washing policy and procedures on or before April 30th 2015 by the Assistant Director of Nursing with a posttest to validate understanding with a required 95% to pass. Posttest will be graded by the Assistant Director of Nursing or Director of Nursing. RNS, LPNS and CNAS will be observed during meal times to ensure handwashing is completed as per policy between residents at mealtimes daily across all meals for 2</p>	



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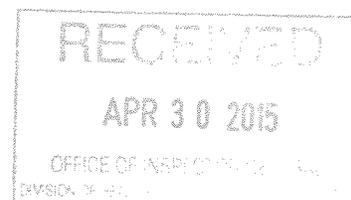
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F 441	Continued From page 39 residents with meals.  Observation of the noon meal service in the Joy Dining Room, on 04/07/15 at 12:27 PM, revealed CNA #4 moved from resident to resident without sanitizing hands. She was observed going to Unsampld Resident A and picking up the spoon and feeding the resident a few bites of food then giving the spoon to the resident. She touched the resident on the shoulders and moved the wheelchair closer to the table then left the dining room to take a tray off the food cart. She delivered the tray to Unsampld Resident D and set the tray up for the resident. She touched the resident's hair and shoulder then went to Unsampld Resident B and repositioned the resident's wheelchair and picked up the resident's glass for the resident to hold. She then went to Unsampld Resident C and sat down and began feeding the resident. She dropped the spoon to the floor, picked it up and placed it on the counter then returned to feeding the resident. She was not observed to wash/sanitize her hands before or after direct contact with a resident.  Interview with CNA #4, on 04/07/15 at 2:40 PM, revealed she had received training on handwashing/sanitizing and forgot to wash her hands. She stated she was in a hurry and should have washed/sanitized her hands between residents where she had direct contact to prevent the transmission of germs that could make residents sick.  Interview with Licensed Practical Nurse (LPN) #4, on 04/08/15 at 2:02 PM, revealed handwashing/sanitizing should occur after any direct contact with a resident and using utensils the resident had touched.	F 441	weeks then 3 times per week times 2 weeks then as determined by the monthly Quality Assurance/Performance Improvement Committee with corrective action at the time of observation.  4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Quality Assurance/Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.  5. Completion Date:	5/2/15	



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F 441	Continued From page 40  Interview with the Director of Nursing, on 04/09/15 at 2:50 PM, revealed nursing staff were trained to wash/sanitize their hands before and after direct resident contact and after picking up a spoon off the floor. She stated this could cause residents to be sick.	F 441			



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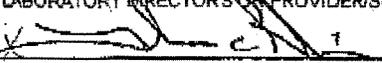
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III, Unprotected Construction.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete, automatic, dry sprinkler system.</p> <p>GENERATOR: Type II, 200 KW generator, installed in 1991. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/07/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire.)</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>K000</p> <p>Owenton Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X8) DATE <b>04/30/15</b>
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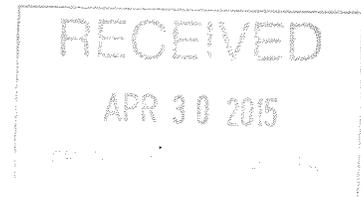
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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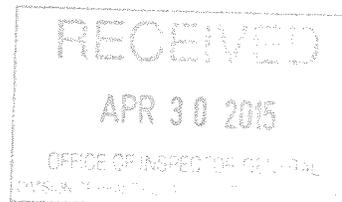
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K 000	Continued From page 1 Fire).	K 000			
K 056 SS=D	Deficiencies were cited with the highest deficiency identified at "E" level.  NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-eight (88) on the day of the survey. The facility failed to ensure sprinkler head spray patterns were not obstructed.  The findings Include:	K 056	K 56  1. The Maintenance Director will order and install new lights in the Janitor Closet and Dietary Managers office and placed at least 12" from the sprinkler heads on or by 04/28/2015.  2. All residents have the potential to be affected. A complete audit was conducted by the Maintenance Director on 04/14/2015 to identify any other lights that may be mounted within 12" of a sprinkler head. All other areas were in compliance.  3. Re-education was given to the Maintenance Director on 04/28/2015 by the Administrator with a posttest to validate the understanding regarding any future installed lights or sprinkler heads need to be mounted with a separation that is at least 12" from one another maintaining the automatic sprinkler		



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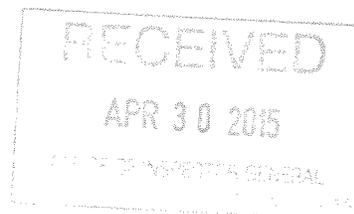
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K 056	<p>Continued From page 2</p> <p>1. Observation, on 04/07/15 at 11:45 AM, with the Maintenance Director revealed the sprinkler head located in the Janitor's Closet within the 200 Short Hall had its spray pattern obstructed by a surface mounted exit light fixture. The light fixture was positioned less than six (6) inches from the sprinkler head and extended further down from the ceiling than the sprinkler head fusible link did.</p> <p>Interview, on 04/07/15 at 11:47 AM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixtures would obstruct the spray pattern of the sprinkler head upon activation of the automatic sprinkler system.</p> <p>2. Observation, on 04/07/15 at 1:11 PM, with the Maintenance Director revealed a sprinkler head located within the Dietary Manager's Office. The office was located within the Kitchen and the sprinkler head had its spray pattern obstructed by a surface mounted light fixture. The light fixture was positioned less than six (6) inches from the sprinkler head and extended further down from the ceiling than the sprinkler head's fusible link did.</p> <p>Interview, on 04/07/15 at 1:13 PM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixtures would obstruct the spray pattern of the sprinkler head upon activation of the automatic sprinkler system.</p> <p>The census of eighty-eight (88) was verified by the Administrator, on 04/07/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview</p>	K 056	<p>system in accordance with National Fire Protection Association (NFPA) standards and that any lights installed by the Maintenance Director will be at least 12" from a sprinkler head. This test will require 95% to pass and be graded by the Administrator.</p> <p>4. The Maintenance Director will conduct observations audits monthly throughout the center to ensure that the automatic sprinkler system is maintained in accordance with National Fire Protection Association (NFPA) standards.</p> <p>The Maintenance Director will submit a summary of the findings to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Medical Records Director, Dietary Manager, Maintenance Director, Unit Managers, Social Service Director, MDS Coordinator</p>		



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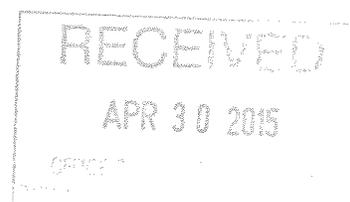
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K 056	Continued From page 3 on 04/07/15.  Reference:  NFPA 101 (2000 Edition)  4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.  NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.  5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing. Shall comply with 5-5.5.2.  Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head.  NFPA 25 (1998 Edition)  2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected.	K 056	and Medical Director monthly for review and recommendations for six months.  5. Completion Date:	5/2/15



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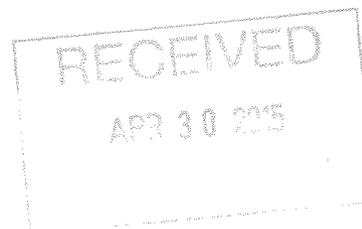
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K 076 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of the four (4) smoke compartments, residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-eight (88) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 04/07/15 at 11:23 AM, with the Maintenance Director revealed an unattended oxygen cylinder located within resident room 208 that was not secured in a rack to prevent falling or being knocked over.</p> <p>Interview, on 04/07/15 at 11:25 AM, with the</p>	K 076	<p>K76</p> <ol style="list-style-type: none"> <li>1. The O2 cylinder that was discovered not in a rack in room 208 was placed in a rack on 04/07/15 by the Maintenance Director. The Maintenance Director moved the light switch that was below 5' inside the Oxygen Storage Room to the outside of the room in the hallway on 04/14/2015.</li> <li>2. All residents of the facility have the potential to be affected. The Maintenance Director conducted an audit of the other rooms on 4/7/15 and all other cylinders in resident rooms were already placed in a rack. There are no additional oxygen storage rooms located in the facility.</li> <li>3. Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) will be re-educated by 05/01/2015 by the Nurse Practice Educator (NPE) on proper storage or placement of oxygen cylinders. In particular, all oxygen cylinders that are placed in resident</li> </ol>



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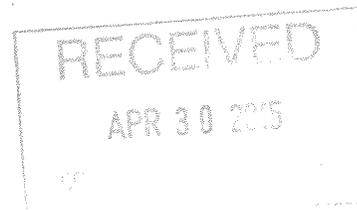
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K 076	<p>Continued From page 5</p> <p>Maintenance Director revealed he was unaware the oxygen cylinder was improperly stored, and unattended within a resident's room. The Maintenance Director acknowledged the potential hazard involved.</p> <p>2. Observation, on 04/07/15 at 11:55 AM, with the Maintenance Director revealed the Oxygen Storage Room located in the 200 Short Hall had a light switch installed within the room and located below five (5) feet from the floor.</p> <p>Interview, on 04/07/15 at 11:57 AM, with the Maintenance Director revealed he was not aware of the requirement that any electrical ignition source located within the Oxygen Storage Room was required to be installed above five (5) feet from the floor and acknowledged the potential hazard involved.</p> <p>The census of eighty-eight (88) was verified by the Administrator on 04/07/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/07/15.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>4-3.1.1.2 Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.</p> <p>8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3)</p> <p>(a) Storage locations shall be outdoors in an</p>	K 076	<p>rooms need to be placed in a rack with a posttest to validate the understanding of proper oxygen storage. This test will require 95% to pass and be graded by the NPE. RNs, and LPNs, not available during this time will be provided re-education including posttest by the NPE.</p> <p>The Administrator re-educated the Maintenance Director on 04/28/2015 that all light switches located in oxygen storage rooms need to be at least 5' from the floor rack with a posttest to validate the understanding. This test will require 95% to pass and be graded by the Administrator.</p> <p>The Maintenance Director will conduct-daily rounds X2 weeks, then conduct rounds 3X a week for 2 weeks, and then weekly for 8 weeks to ensure all oxygen cylinders are properly placed in resident rooms. Any concerns will be immediately corrected.</p>	



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

PRINTED: 04/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/07/2015
NAME OF PROVIDER OR SUPPLIER  OWENTON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359	
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K 076	Continued From page 6 enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076	4. The Maintenance Director will submit a summary of the findings to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Medical Records Director, Dietary Manager, Maintenance Director, Unit Managers, Social Service Director, MDS Coordinator and Medical Director monthly for review and recommendations for six months. 5. Completion Date: 5/2/15



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K 076	Continued From page 7  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			

