

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

PRINTED: 11/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey and abbreviated survey was conducted 10/26-10/28/10 and was found not to meet the minimum regulatory requirements. Deficiencies cited were under 483.15 F253 S/S "E", 483.20 F279 S/S "E", 483.25 F309 S/S "G", F334 S/S "D", 483.60 F431 S/S "D", and 483.65 F441 S/S "D". A Life Safety Code survey was completed on 10/27/10 with the highest S/S of an "F". Complaints KY #14554, KY #15116, KY #14494, KY #14495, and KY #14553 were investigated in conjunction with the annual health survey. KY14554, KY15116, KY14495 and KY14553 were all substantiated, with the highest S/S of a "G". KY14494 was unsubstantiated.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure housekeeping and maintenance services maintained a sanitary, orderly and comfortable interior. There were five rooms with evidence of ceiling leaks, one room had a stopped up sink, two rooms had commodes that were loose, two over bed lights had no strings, three rooms had bubbled wallboard behind the commodes and one room had no cold water handle. The findings include:	F 253	F253 I. How corrective action will be accomplished for those affected. 1. Rooms # 41, 43, 45, 47 and 49 ceiling were checked to insure no leaks and roof was check and any loose shingles were properly secured by Maintenance Director on 10/29/10. In addition ceiling stains were painted to maintain interior. 2. Rooms # 8 plumber arrived at facility on 10/27/10 and sink drain issue was resolved on 10/27/10. 3. Rooms # 1 and 7 commodes were tightened to insure commodes were not loose on 10/27/10 and were caulked on 10/28/10. 4. Rooms 25 and 48 were supplied with a proper pull string to insure Residents could turn the light on and off independently on 10/27/10. 5. Rooms 5, 7 and 14 were repaired and properly sanitized and were affixed with wallboard protection to prevent further damage to wallboard. Issue resolved on 11/12/10. 6. Room # 5 was affixed with a cold water faucet handle on 10/28/10. II. How corrective action will be accomplished for those residents having potential to be affected. Entire staff in-serviced on the use of the maintenance repair log located at each nurses station. Staff educated to promptly record	11/22/10

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

TITLE

(X6) DATE

[Signature] Executive Director X

11/10/10

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.

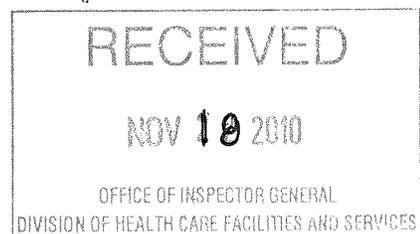
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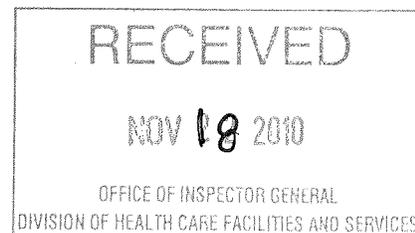
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F 253	Continued From page 1 Observation of resident rooms #41, 43, 45, 47, and 49 on 10/27/10 at 11:30am revealed ceilings with stains of varying sizes that appeared to be caused by a leaking ceiling. Observation of resident room #8 on 10/26/10 during the initial tour at 9:00am to 10:00am revealed a sink with standing soapy water. There was a sign in the bathroom above the sink that said not to use the sink due to it being stopped up. The sign was dated 10/18/10. Observation on 10/27/10 at 11:35am revealed the sink still had standing water in it. There was now a sign that stated not to use the sink and that a plumber had been called on 10/27/10. Observation of resident rooms 1 and 7 on 10/26/10 during the initial tour at 9:00am to 10:00am revealed commodes that were loose and not caulked. Observation of resident rooms 25 and 48 on 10/26/10 during the initial tour at 9:00am to 10:00am revealed there was no pull string present on the overbed light fixture so residents could turn the light on and off independently. Observation of resident rooms 5, 7 and 14 on 10/26/10 during initial tour 9:00am to 10:00am revealed the wallboards behind the commodes are bubbled from apparent water damage. Observation of resident room 5 on 10/26/10 during the initial tour at 9:00am to 10:00am revealed there was no cold water faucet handle on the bathroom sink. Interview with the Maintenance Supervisor on	F 253	_____ issues in the log which is reviewed three times daily by Maintenance Director. In addition Administrator will review log weekly to insure issues are resolved. Completed 11/22/10. III. What measures will be put in place/systemic changes made to ensure correction. Staff will be in-serviced annually on the proper use of the maintenance log as well as education will be included in new hire orientation. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator will review maintenance log weekly and insure issues are addressed. In addition Administrator will make monthly facility room rounds, with Maintenance Director, to identify any potential issues and insure any maintenance problems are properly attended too. Results of the rounds will be recorded and reported to the quality assurance committee to insure proper action is taken.	11/22/10



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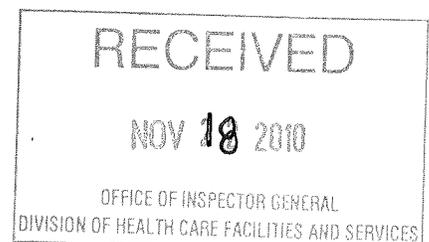
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F 253	Continued From page 2 10/28/10 at 3:30pm revealed he was not aware of the above findings. He stated that he keeps a log at the nurses' station on both North and South units. The log is to be filled out by the nurses listing the date, area involved and a description of the problem. He stated that he checks that log three times daily and initials it when it is complete. He revealed that he also keeps a notebook and writes down what needs to be done, then throws away the pages as he completes tasks listed on that page. He revealed that he does have preventive maintenance schedules for dietary, life safety code, nursing equipment, and call systems. He stated he does not have a preventive maintenance schedule specifically for resident rooms.	F 253		11/22/10
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 I. How corrective action will be accomplished for those affected. 1. Resident #3 & 17; the facility contacted Hosparus on each of the respective Residents and integrated the respective hospice plan of care with the facilities plan of care (completed on 10/29/10). In addition the facility schedule a IDT meeting with the Hosparus representative to insure Residents plan of care was properly Residents needs were properly care planned. II. How corrective action will be accomplished for those residents having potential to be affected. Nursing staff as well as Social Service staff will be in serviced on proper integration of hospice services in residents plan of care. The facility's Director of Nursing will review all residents	



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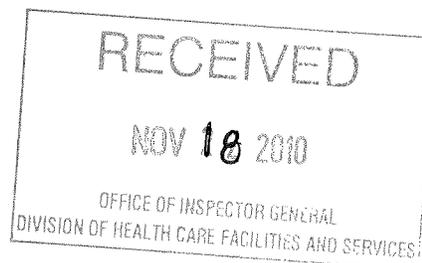
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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review and revise the comprehensive care plans of two (2) of the twenty-two (22) sampled residents (#3 and #17). The facility failed to integrate the facility's care plan and the Hospice care plan. The findings include: Record review of the facility's Hosparus Nursing Facility Agreement (HNFA) Version 11/2008 revealed a plan of care is developed for each resident using an interdisciplinary approach and the care plan will be jointly developed and agreed upon which is consistent with the hospice philosophy and is responsive to the unique needs of the resident. The facility's HNFA revealed the plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care. The facility's HNFA revealed the plan of care is to include the facility's services, identification of the Hospice Services, including the interventions for pain management and symptom relief. Review of the facility's Care Plan Policy (CPP) dated 10/31/09 (Revised) revealed a comprehensive care plan is developed that is consistent with the residents' specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and time tables to meet the resident's needs as identified in the resident's assessment, or as identified in relation	F 279	_____ currently under hospice care and schedule a IDT meeting to include the respective hospice representative to insure the proper plan of care is developed to attend to the respective residents needs. Completed 11/22/10. III. What measures will be put in place/systemic changes made to ensure correction. The facility will annually in-service appropriate staff on the integration of hospice services in residents plan of care. The in-service will also be provided to appropriate new hire during orientation. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing will also review hospice residents plan of care monthly to insure that residents receiving hospice care will have there plan of care properly integrated and there needs are properly addressed. Results of the review will be reported to the quality assurance committee monthly and proper action will be taken as a result of the review.	11/22/10



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F 279	Continued From page 4 of the resident's response to the interventions or changes in the resident's condition. The CPP compliance guidelines revealed the Interdisciplinary team includes the attending physician, a licensed nurse with the responsibility for the resident, and other appropriate staff as determined by the resident's needs, such as nutrition, social services, activity, rehabilitation services, Hospice/Palliative Care Services and mental health services. The CPP compliance guidelines revealed the resident, legal surrogates and Representatives are encouraged to participate in care planning, including attending care plan conferences, if they so desire. The CPP compliance guidelines revealed the team of qualified persons monitors the resident's condition and the effectiveness of the care plan interventions, and revises the care plan quarterly, annually, with a significant change assessment or more frequently with the input by the resident and/or the representative, based on the following: a. achieving the desired outcome; b. the resident's failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; c. change in the resident's condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems. The CPP compliance guidelines revealed when the resident has elected the Hospice benefit, the Hospice and the Nursing Home communicate, establish, and agree upon a coordinated plan of care for both providers that reflects the Hospice philosophy, and is based on an assessment of the resident's individual needs and unique living situation in the center. The CPP compliance guidelines revealed the plan of care includes directives for managing pain and other uncomfortable symptoms revise and update as necessary to reflect the resident's	F 279		



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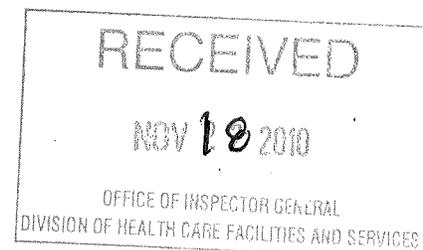
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F 279	<p>Continued From page 5</p> <p>current status. The facility's CPP listed under 6. c. the plan of care includes directives to identify the care and services which the skilled nursing facility/nursing facility (SNF/NF) and Hospice will provide in order to be responsive to the unique needs of the resident and his/her expressed desire for Hospice care. The facility's CPP revealed the facility and Hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The facility identified in the CPP that Hospice retains overall implementation of the plan of care related to the terminal illness and related conditions.</p> <p>Record review of the facility's Terminal Illness Policy (TIP) dated 04/28/09 (Revised) revealed the residents with terminal illness will receive palliative care through the duration of their illness as identified by the Interdisciplinary Team. Review of the TIP compliance guidelines revealed the resident's spiritual, legal, financial and emotional needs are assessed and are care planned. Review of the TIP compliance guidelines revealed a Hospice referral is made unless services are not available to the center, a resident refuses Hospice services, or a family/responsible party refuses the Hospice services. Review of the TIP compliance guidelines revealed the Hospice services are coordinated with the Hospice provider by the Interdisciplinary Team to ensure that the resident's needs are addressed and met.</p> <p>Record Review revealed Resident #3 was admitted on 01/15/10 with diagnoses of; Senile Dementia, Psychosis, Dementia, Depression, Hypertension and Hypopotassemia. On 08/30/10 Resident #3 was admitted to Hosparus to receive</p>	F 279		
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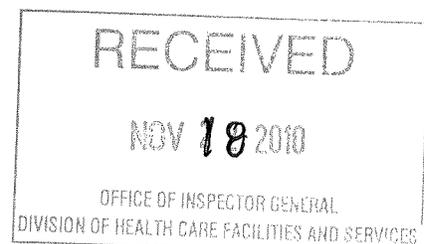
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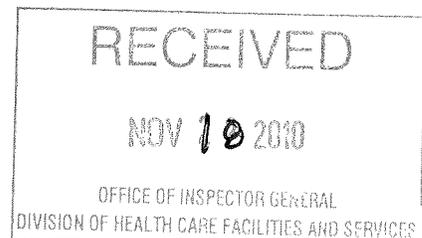
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F 279	<p>Continued From page 6</p> <p>Hospice services. A review of the facility's plan of care on Resident #3 did not identify which care and services Hosparus will provide. There was no evidence of coordination for services provided between the facility and Hosparus.</p> <p>Record Review on 10/28/10 revealed Resident #17 was admitted on 10/26/09 with diagnoses of; Alzheimer's Disease, Dementia without Behaviors, Anxiety, Depression, Diabetes Mellitus-Type II, and now with Adult Failure to Thrive. On 01/15/10 Resident #17 was admitted to Hosparus to receive Hospice services. The record review of the facility's plan of care on Resident #17 does not identify which care and services Hospice will provide. There is no evidence of coordination for services provided between the facility and Hosparus.</p> <p>Interview with the Hospice Nurse (HN) on 10/28/10 at 10:20am revealed the facility has not at any time extended an invitation to attend the facility's Interdisciplinary Team (IDT) meeting to discuss and coordinate Resident #3 or Resident #17's care and services. The Hospice Nurse reported that he/she sees Resident #17 two times per week and has requested from the social services department an interest to attend the IDT meetings to report and discuss care and services on Resident #3 and Resident #17 but has never been notified of the time and place to be able to attend the meeting. The Hospice Nurse reported the facility does not routinely notify Hospice and coordinate the resident's care. The Hospice Nurse reported Resident #17 had been put on an antibiotic regime with an intramuscular (IM) injection method of administration and was not notified of any changes prior to this visit. The Hospice Nurse reported the Hospice approach</p>	F 279		



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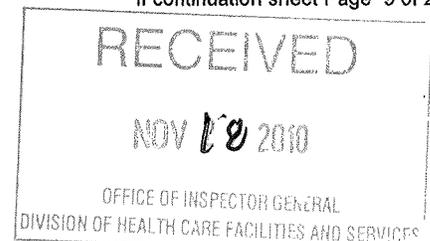
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F 279	Continued From page 7 would have been a different method to avoid the IM injection everyday for five (5) days related to Resident #17's minimal muscle mass. The Hospice Nurse reported Hospice was not notified that Resident #17 had developed a need for the antibiotic, and only found the information on the chart at the time of the resident's Hospice visit. Interview with Registered Nurse (RN) #1, regarding the care and services of Hospice residents, on 10/28/10 at 8:27am revealed Hospice does follow a couple of the residents for Hospice services. The RN reported Resident #3 and #17 both have Hospice services with a Hospice RN and a Hospice Certified Nurse Assistant (HCNA). The RN reported he/she provides care to the residents and does not specifically call Hospice when a resident has a need. In addition, the Hospice Nurse is not routinely notified when something is needed for the resident. The RN stated the Hospice Nurse comes a couple times a week to the facility and this is when the Hospice Nurse sees any new orders for the resident on the resident's chart. RN #1 reported the facility nurses call the doctor for whatever they need. RN #1 was unable to verbalize the specific interventions provided by the Hospice Nurse or the Hospice CNA. The RN stated Resident #3 receives the services of a Hospice Nurse only and Resident #17 receives services of a Hospice Nurse and a Hospice CNA. The RN continued by stating that he/she was unable to identify the specific services each modality provided. In addition, he/she was unable to provide evidence a care plan for Resident #3 and Resident #17 was integrated to identify the specific services each service was to provide for the resident.	F 279		



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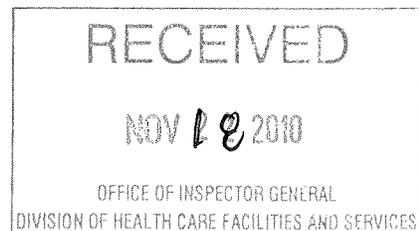
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F 279	Continued From page 8 Interview with CNA #2 on 10/28/10 at 8:15am revealed he/she was unable to provide evidence the Hospice Care Plan and the facility's CNA care plan for the Hospice residents were integrated for care and services. The CNA reported the Hospice CNA for resident #17 comes to the facility two times a week and that she only knows that because he/she works on this unit, but this is not written down anywhere else. In conclusion, the CNA reported there was nothing written down to say who does what services. Interview with RN #4 on 10/28/10 at 8:59am revealed the RN has the responsibility for developing and implementing the care plans. The RN was unable to provide evidence the Hospice Care Plan and the facility's care plan for the Hospice residents were integrated for care and services. RN #4 reported he/she had never merged the resident's care plan with the Hospice care plan. In addition, the RN reported the Hospice CNA for resident #17 comes in now and then, maybe two times a week. Interview with Director of Nursing (DON) on 10/28/10 at 3:45pm revealed she has the responsibility to ensure the nursing staff fulfills the contracts with Hosparus and meets the residents care needs and services. The DON reported she had never reviewed the Hospice Contract and was not aware of the requirements. She reported she was not aware the care plans were suppose to coordinate the services provided. She reported she was not aware Hospice services were not invited to attend the IDT meetings for the Hospice residents.	F 279		11/22/10
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 I. How corrective action will be accomplished for those affected.	



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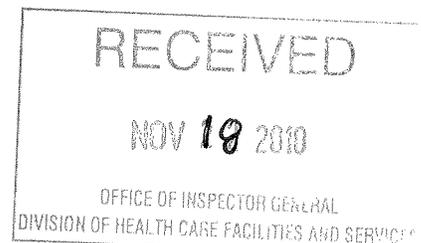
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F 309	<p>Continued From page 9</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with medical orders, the comprehensive assessment and plan of care for one (1) of twenty two (22) sampled residents (#20). The facility failed to provide pain medication in a timely manner to Resident #20, as the first dose was not administered until approximately 20 hours after Resident #20 was admitted. Resident #20 was documented as having an 8 out of 10 pain level scored the day of admission. The facility failed to follow the Pain Management Policy as it related to pain persisting and the need for pharmacological intervention. In addition, there was a three (3) day delay in providing incentive spirometer treatments (medical equipment used to measure how well resident's lungs are filling with air during breathing), after the resident had a collapsed lung, as ordered at time of admission for Resident #20.</p> <p>The findings include: Policy Review revealed Pain Management Policy</p>	F 309	<p>Resident cited in deficiency was discharged from facility on 2/26/10.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected.</p> <p>Facility will not admit residents to facility without obtaining prescription for schedule II narcotics prior to admission or prescription being delivered upon residents arrival to the facility. Director of Nursing or designee will complete admission audit for all new admissions within 24 hours of admission. Director of Nursing or designee will review MAR on all new admissions for 30 days, and 10 quarterly for 6 months. Facility will in-service appropriate staff on the new admission guidelines. Completed 11/22/10.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction.</p> <p>Completion of admission audits for all new admissions with in 24 hours of admission and review of medication record for admission by Director of Nursing or designee.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Results from reviews and audits will be recorded and presented in the facilities quality assurance meeting monthly.</p> <p><i>See attached email addendum for facility revision MZ</i></p>



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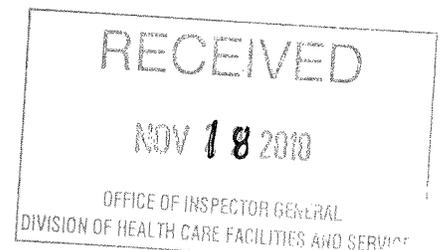
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F 309	<p>Continued From page 10 (PRO 61018) #8 date 04/28/09 "Consult with the physician for a change in condition, pain persisting or recurring despite treatment or there is a need for pharmacological intervention, or change in pharmacological intervention."</p> <p>Record review of the facility's Hosparus Nursing Facility Agreement (HNFA) Version 11/2008 revealed a plan of care is developed for each resident using an interdisciplinary approach and the care plan will be jointly developed and agreed upon which is consistent with the hospice philosophy and is responsive to the unique needs of the resident. The facility's HNFA revealed the plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care. The facility's HNFA revealed the plan of care is to include the facility's services, identification of the Hospice Services, including the interventions for pain management and symptom relief.</p> <p>Record review revealed that Resident #20 was admitted on 02/19/10 at approximately 4:40pm with diagnoses of; Pneumothorax (collapsed lung), Multiple Rib Fractures, Fracture C2 Vertebra-Closed, Hydronephrosis (distended kidney), Contusion of Thigh, Benign Prostate Hypertrophy (BPH) without Urinary Obstruction, Calculus of Ureter (stones), and Osteoarthritis. Resident #20 had been involved in a tractor rollover accident and was treated at a local hospital for ten days prior to transfer to facility for rehabilitation services. LPN #1 completed the Pain Assessment on Resident #20 at 4:40pm on 02/19/10 and documented that Resident #20 had a pain score of 8 on a 10 point scale. The assessment detailed that Resident #20 verbalized</p>	F 309			



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F 309	<p>Continued From page 11</p> <p>or exhibited non-verbal symptoms of pain which was present at time of admission. LPN#1 documented the resident experienced pain on the right side of the resident's chest, left leg and had chronic pain. Further, the resident described the pain as an ache, tender and throbbing. The assessment detailed the resident was grimacing and moaning and specified the cause of pain was multiple rib fractures and movement causes and increases pain. Resident #20's acceptable level of pain was a 4 out of 10. Resident #20 had an order for Vicodin 5/500 mg one to two every four to six hours as needed for pain. The pain assessment form detailed that pain was relieved by medication and that pain management intervention was necessary.</p> <p>Record review revealed a Nurse's Note on 02/19/10 at 11:00pm signed by LPN #1 which indicated Resident #20 complained of pain to touch and right heel pain.</p> <p>Record review revealed the facility had a copy of a prescription dated 02/19/10 from a local hospital for Lortab 5/500 mg, one to two by mouth every four to six hours as needed for pain.</p> <p>Record review revealed a note cosigned by LPN #2 to use one Lortab 5/500 mg tablet from Emergency Drug Kit and indicated the prescription was left in the narcotics Emergency Drug Kit.</p> <p>Record review revealed Resident #20 received the first dose of Lortab 5/500 mg at 1:00pm on 2/20/10 at which time Resident # 20 rated his/her pain at a 6 out of 10. This first dose was administered approximately 20 hours after Resident #20 was admitted.</p>	F 309			



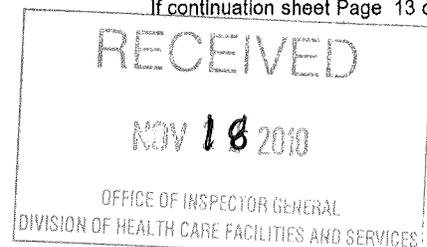
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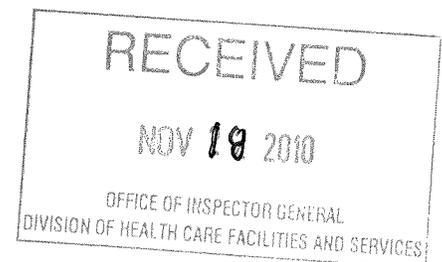
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F 309	<p>Continued From page 12</p> <p>Interview with LPN #1 on 10/28/10 at 1:20pm revealed that while she did remember Resident #20, she could not remember if the resident complained of pain or asked for pain medication.</p> <p>Interview with Resident #20's family member, on 10/28/10 at 4:20pm revealed Resident #20 did not receive pain medication until after the family member arrived to the facility on 02/20/10 and requested the medication for Resident #20. The family member reported that he/she was told by a nurse at the facility that the medication had not yet arrived. The pharmacy had already delivered for that day and there would be no more deliveries for two days since it was the weekend.</p> <p>Interview on 10/28/10 at 7:25pm with Resident #20 revealed that he/she had never had such a bad night. When asked if he/she had pain that night the resident stated yes he/she was hurting and had tried to get some help. When asked if he/she had requested pain medication the resident stated "I couldn't get nobody in there to ask for nothin." Resident #20 was asked if he/she reported pain when the nurse did the initial assessment, and the resident stated he/she did not remember the initial assessment. The resident reported that some girl came in and he/she told the girl that he/she was in pain and needed to go to the bathroom but the girl stated she was not going to break her back, the resident stated that he/she never saw anyone else. The resident stated he/she thought that was around 9:00pm. Resident #20 stated pain medications were not received.</p> <p>Interview with Director of Nursing on 10/28/10 at 3:30pm revealed that if a resident had a reported</p>	F 309		



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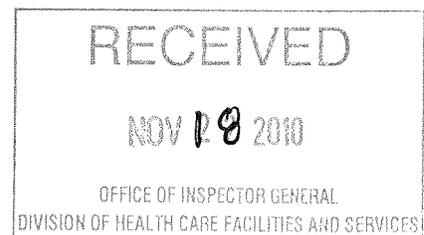
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F 309	Continued From page 13 pain level 8 the expectation would be for the resident to receive pain medication within one (1) hour. She revealed that a nurse could get medication from the EDK (emergency drug kit) with a doctor's order and pharmacy okay. For Schedule 2 narcotics, the nurses can get an emergency supply from Walgreen 's within four (4) hours as long as there was a handwritten prescription on hand. Record review revealed the facility had a copy of a prescription dated 02/19/10 from a local hospital for an order for Incentive Spirometer every hour. Record review on Resident #20 revealed no documentation on the Treatment Record that the Incentive Spirometer was used until 02/22/10, three (3) days after the 02/19/10 admission. Interview with LPN #1 on 10/28/10 at 5:45pm revealed that she did not remember using the Incentive Spirometer on Resident #20. Interview with Director of Nursing on 10/28/10 at 3:30pm revealed that the expectation would be that incentive spirometer treatments would be started within the first hour after the resident arrived at facility with orders. She stated that with an order for every hour incentive spirometry, the expectation would be for that order to be carried out during the night as well as during the day. When asked about the rules of documentation she revealed that if it is not documented it is not done.	F 309		11/22/10
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334	F334 I. How corrective action will be accomplished for those affected. 1. Resident #13 was given education related to influenza immunization and facility obtained the signed annual declination consent. II. How corrective action will be accomplished for those residents having potential to be affected.	



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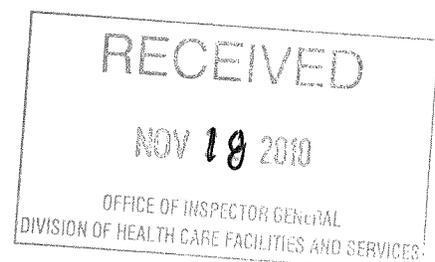
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F 334	<p>Continued From page 15</p> <p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure each resident, or the resident's legal representative received education before offering the influenza immunization, regarding the benefits and potential side effects of the immunization. In addition, the facility failed to obtain the annual signed consent for one (1) of the twenty-two (22) sampled residents.</p> <p>The findings include:</p> <p>Record review of the facility's Immunizations Policy (IP) dated 10/01/07 revealed the risk of residents acquiring, transmitting, or experiencing</p>	F 334		



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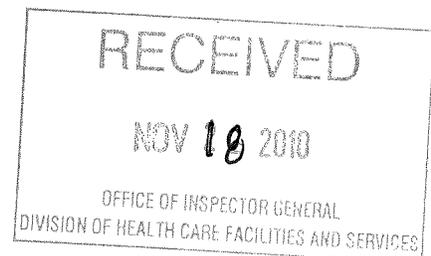
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F 334	<p>Continued From page 16</p> <p>complications from influenza and pneumococcal pneumonia is minimized through education of the residents and staff.</p> <p>Record review of Resident #13 on 10/26/10 revealed the resident was admitted to the facility on 04/26/06 with the diagnoses of; Multiple Sclerosis, Muscle Spasms, Joint Contractures and Depression. The record review revealed the facility assessed Resident #13 with cognitive skills for daily decision making fully intact and without impairments.</p> <p>Record review of Resident #13 on 10/26/10 revealed the resident was offered but declined the influenza immunization on 10/07/09 and 10/13/10 without documentation of the education provided, and without documentation of a signed annual declination consent for the 2009 and the 2010 influenza season. Record review of the 2009 and the 2010 immunization record revealed the resident refused the immunization.</p> <p>Record review of Resident #11 on 10/26/10 revealed the resident was admitted to the facility on 07/23/10 with the diagnoses of; Hypertension, Alzheimer's Disease and Hypothyroidism. The record review revealed the facility was unable to provide evidence of education in the medical record during the onsite standard survey on 10/26/10. However, on 11/05/10 the facility did provide additional information of documentation in the resident's business/financial file.</p> <p>Interview with RN #1 on 10/28/10 at 8:30am revealed he/she is responsible to provide the residents with the flu shots each year. The RN reported the immunization consents are only obtained on admission and not annually. The RN</p>	F 334			



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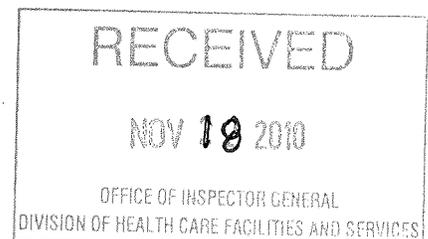
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F 334	Continued From page 17 stated the education information was given out last year, and had not seen any of the education sheets that are provided to the residents this year. The RN reported he/she did not believe there were any of the education sheets for the residents in the building at this time. RN #1 further stated the only role he/she had was to give the flu shots and that the flu shots had already been given to the current residents in the facility. In conclusion, the RN reported that he/she was not aware the facility had to get a consent signed every year. Interview with the Director of Nursing (DON) on 10/28/10 at 4:30pm revealed the education component for the Fall 2010 Influenza Season was with the current billing statements. The DON reported the immunization education and consent were only completed on the initial admission, and not done annually. Interview with the Executive Director (ED) on 10/28/10 at 6:00pm revealed the education component for the Fall 2010 Influenza Season was being mailed with the current billing statements, and the current billing statements had not been mailed yet. The ED reported the Fall 2010 immunizations for the influenza were given prior to providing the immunization education and prior to obtaining current signed consent forms from the residents and/or their representative.	F 334		11/22/10	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431 I. How corrective action will be accomplished for those affected. 1. LPN observed in medication pass received on the spot education related to properly securing medication cart. 2. Medication in question removed from cart and properly disposed of.		



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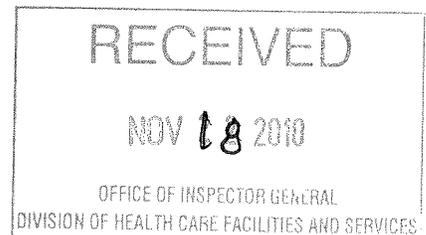
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F 431	<p>Continued From page 18</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain a properly secured medication cart during medication administration pass and maintain medications in properly labeled containers in one (1) medication cart.</p>	F 431	<p>II. How corrective action will be accomplished for those residents having potential to be affected.</p> <p>All licensed nursing staff to receive in-service related to properly securing medication cart. Completed 11/22/10. New medication cart cleaning schedule implemented to include nightly cleaning of medication carts. Director of Nursing or designee will review at minimum three, 3, medication passes per week for thirty days to insure proper hand washing technique is administered. In addition the Director of Nursing or designee will review medication pass ten, 10, quarterly for a period of one, 1, year to assure proper technique is administered.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction. Medication pass results will be recorded by the Director of Nursing or designee with results being tracked by the Director of Nursing.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Results from audits and reviews to be reported to facility quality assurance committee.</p>	11/22/10



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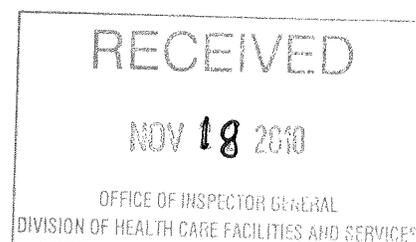
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F 431	<p>Continued From page 19</p> <p>The findings include:</p> <p>Record review of the Medication Administration policy revealed during medication pass the cart must be secured. Furthermore, medications must be under direct observation of the person administering the medications or locked in the medication storage area/cart.</p> <p>Observation on 10/27/10 at 8:15am of the medication pass with Licensed Practical Nurse (LPN) #7 revealed the medication drawer was left unattended and unlocked during medication pass to a resident located on the south hallway.</p> <p>Interview on 10/27/10 at 9:00am with LPN #7 revealed the nurse did not realize the cart was left unlocked. The LPN stated that leaving the cart unattended was a possible risk for someone to steal the medications or for someone to take medications they should not have access to. LPN #7 also stated it would be dangerous and could potentially harm a resident or anyone who got into the unlocked medication cart and took medications.</p> <p>Interview on 10/27/10 at 10:10am with the Director of Nursing (DON) revealed the medication cart does not need to be locked if it is in visible sight of the person administering medications. If the medication cart is out of visual perception, the cart needed to be locked.</p> <p>Interview on 10/28/10 at 9:15am with Registered Nurse (RN) #1 revealed regardless of whether the cart is sitting in the doorway of a resident's room or not, the medication cart is always locked because you just never know if a resident will be confused and wander up to the med (medication)</p>	F 431		



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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 20</p> <p>cart. Furthermore, secure cart means you would have to have direct eye contact with the cart. The RN added that confused residents have attempted to pull medication cards during the medication pass which is why RN #1 always locks the medication cart when away from the cart.</p> <p>Record review of the Medication Storage Policy for the facility revealed that medications are kept in the containers dispensed by the pharmacy. Furthermore, remove and dispose of medications according to procedures for medication disposal that are outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures from stock.</p> <p>Observation on 10/27/10 5:15pm during the Front South medication cart inspection revealed, one white pill with a gray color tinge was visibly seen under the cup and utensil organizer on the top of the medication cart. Also, located in the top drawer of the medication cart was one (1) small white round pill, one (1) red oblong pill, one (1) peach colored pill and in the second drawer of the medication cart half of a pink pill was found loose in the drawer.</p> <p>Interview on 10/27/10 at 5:20pm with LPN #8 revealed the nurse was not sure where the pills came from. The LPN revealed that during medication administration, all of the medications for each resident is taken out and placed on top of the medication cart for each resident, and then the pills are popped out of a blister pack into a cup.</p> <p>Interview on 10/27/10 at 10:10am with the DON revealed that a nurse should dispose of</p>	F 431		



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

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F 431	Continued From page 21 medications immediately in the sharps container if discovered in a drawer and out of the blister pack. Also the DON stated that either way, the pill was under the cup and utensil organizer, out in the open, and there is a risk for potential harm if a resident got the medication.	F 431		11/22/10
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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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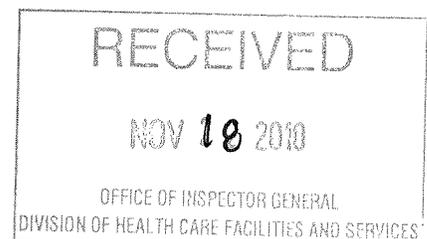
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 22</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 and record review it was determined the facility failed to maintain proper aseptic techniques during medication administration and indwelling catheter peri care.</p> <p>The findings include:</p> <p>1. Record review revealed the Medication Administration policy and procedure is to wash hands as the first step before administering medications.</p> <p>Observation on 10/27/10 at 8:30am on the south hallway, revealed Licensed Practical Nurse (LPN) #7 touched their face and nose area and did not wash their hands after administering medication to a resident and before administering medications to another resident.</p> <p>Interview on 10/27/10 at 9:00am with LPN #7 revealed she should have washed her hands after administering medications to a resident and before beginning medication administration to another resident. There is a risk for infection, and spreading infection, from one room to another and not using aseptic technique.</p> <p>Interview on 10/27/10 at 10:10am with the Director of Nursing (DON) revealed that using</p>	F 441	<p>1. Director of Nursing or designee will review at minimum three, 3, medication passes per week for thirty days to insure proper hand washing technique is administered. In addition the Director of Nursing or designee will review medication pass ten, 10, quarterly for a period of one, 1, year to assure proper technique is administered.</p> <p>2. Director if Nursing or Designee will review the indwelling catheter care of two, 2, residents per week for a period of thirty days. In addition the Director of Nursing or designee will review the indwelling catheter care of six, 6, residents quarterly for a period of one year.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The results of the medication pass and indwelling catheter care will be reported to the facilities quality assurance meeting monthly. Proper action will be taken as a result of the results.</p>	11/22/10



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F 441	<p>Continued From page 23</p> <p>hand sanitizer or washing hands between residents and before going to the next resident is part of the infection control policy.</p> <p>2. Record review of the indwelling catheter care policy revealed the catheter is anchored to prevent excessive tension on the catheter which can lead to urethral tears and dislodging of the catheter. Also, wash perineum beginning at the junction of the catheter tubing and meatus working outward to the surrounding perineal structures with soap and warm water or a no rinse solution cleaning and cleaning from front to back using a circular motion when cleaning.</p> <p>Observation on 10/28/10 at 1:45pm revealed LPN #8 washed the outer labia, then inner labia, and made multiple swipes with the same area of the soiled wash cloth. Also, the indwelling catheter tubing was not securely anchored during peri care and the resident stated "owow" before LPN #8 secured the indwelling catheter tubing.</p> <p>Interview on 10/28/10 at 2:04pm with LPN #8 revealed that the outer labia was washed, and then the inner labia was washed with a wash cloth. Further interview revealed the nurse was not aware the tubing was not anchored securely.</p>	F 441			

