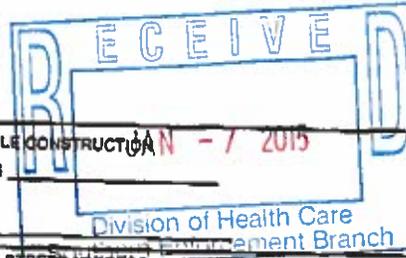


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165150	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  12/11/2014
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NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822
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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 000	INITIAL COMMENTS	F 000		
F 282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure care was provided in accordance with the resident's written plan of care for five (5) of nineteen (19) sampled residents (Residents #2, #8, #10, #12, and #16). Review of the comprehensive care plan for Resident #10 dated 04/03/14, revealed a care plan intervention for the resident to have padded side rails. However, the facility failed to ensure that Resident #10 had padded side rails. In addition, Residents #2, #6, #10, #12, and #16 had plan of care interventions for catheter care to be as ordered/needed. Further, Resident #6 had a care plan intervention to administer oxygen per physician's orders; however, the resident's oxygen was observed not being administered in accordance with the current physician's orders.</p> <p>The findings include: Review of facility policy titled "Care Plan Policy &amp; Protocol," with a revision date of August 2012,</p>	F 282	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ruby Pignatelli* TITLE: Administrator (X8) DATE: 1-7-15

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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F 282	<p>Continuad From page 1</p> <p>revealed the care plan shall be periodically reviewed and revised by the interdisciplinary team after each assessment and on an as needed basis. Continued review of facility policy revealed the Kardex would also be utilized as a guide for Nurse Aides in providing care on a daily basis and that the Kardex was a working tool that would be revised when indicated.</p> <p>A review of the facility's policy titled "Giving Catheter Care," (undated) revealed a resident's catheter tubing was to be coiled and secured. The policy was not specific regarding the manner or means of securing the catheter tubing. An interview with the Director of Nursing (DON) on 12/11/14 at 4:30 PM revealed catheters should be secured using a Cath-Secure device (a Cath-Secure device is a device used to secure the catheter to a resident's leg to prevent pulling).</p> <p>1. Observations made on 12/09/14 at 5:30 PM and on 12/10/14 at 4:32 PM, revealed Resident #10 did not have padded side rails in place as indicated on the resident's comprehensive care plan.</p> <p>Review of Resident #10's medical record revealed the facility admitted the resident on 12/06/06, with diagnoses that included Senile Dementia with Depressive Features, Contracture of Joint, Senile Osteoporosis, Osteoporosis, Decreased Vision, Body Myoclonic Jerking, Moderate/Severe Cognitive Impairment with Agitation, Debility, Deformity/Contracture of Hip/Knee, Delusion, and Advanced Osteoarthritis.</p> <p>Review of Resident #10's most recent Quarterly Minimum Data Set (MDS) assessment dated 09/28/14, revealed the facility assessed Resident</p>	F 282		
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F 282	<p>Continued From page 2</p> <p>#10 to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated that Resident #10 had severe cognitive impairment.</p> <p>Review of Resident #10's comprehensive care plan dated 04/03/14, revealed the resident had potential for skin breakdown related to impaired mobility, incontinence, poor decision-making, thin fragile skin, and heart disease. Further review of Resident #10's comprehensive care plan revealed an intervention to pad the resident's side rails.</p> <p>Review of Resident #10's Resident Kardex (Certified Nursing Assistant Care Plan), undated, revealed Resident #10 was to have three-quarter bilateral side rails but the facility failed to ensure the Nursing Assistant Care Plan included padding for the side rails.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 12/11/14 at 1:28 PM revealed SRNAs were responsible for applying padding to side rails as needed. SRNA #3 stated she had never noticed Resident #10 to have padded side rails in the two years she had worked at the facility, and was not aware that Resident #10 required padded side rails.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 12/11/14 at 1:40 PM revealed she cared for Resident #10 daily and had worked for one year on the hallway where Resident #10 resided. Continued interview with LPN #4 revealed nurses and nurse aides were responsible for making sure padding was present on resident side rails, but she had not observed Resident #10 to have padded side rails at any time.</p>	F 282		
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F 282	<p>Continued From page 3</p> <p>Interview with Registered Nurse (RN) #1 on 12/11/14 at 1:55 PM revealed she was the Unit Coordinator for the unit on which Resident #10 resided. She stated the staff tried to work as a team to make sure residents' care plans were followed, but she was not aware that Resident #10 required padded side rails. Further interview with RN #1 revealed SRNAs were given any new resident care plan updates during shift report and that interventions should be on the Resident Kardex. She stated nursing staff was responsible for ensuring any new orders for residents were followed and that she conducted rounds twice a day (once in the morning and once in the evening) to ensure care plans were being followed and provided staff education as needed.</p> <p>Interview with the Medicare MDS Coordinator on 12/11/14 at 1:02 PM and 2:23 PM revealed that the MDS Coordinators were responsible for updating Resident Kardexes and that they were reviewed monthly for accuracy and updated as needed. She further stated she was not aware that Resident #10 was required to have padded side rails.</p> <p>Interview with the Medicaid MDS Coordinator on 12/11/14 at 3:15 PM revealed she had added the padded side rails to Resident #10's Comprehensive Care Plan following the resident's annual MDS assessment dated 04/02/14 as a precautionary measure. Continued interview with the Medicaid Coordinator revealed she failed to ensure that the intervention had been added to the Resident Kardex and to ensure that the intervention was implemented as noted on the care plan.</p> <p>Interview with the DON on 12/11/14 at 4:20 PM</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>revealed she made rounds to ensure that staff was following residents' care plans. She stated rounds were also made by her, the nurses, or the SRNAs every two hours to ensure care plans were being followed. Continued interview with the DON revealed she was not aware that Resident #10 required padded side rails, but she thought Resident #10 may have had padded side rails at some point in the past. The DON stated that if Resident #10 no longer needed the padded side rails intervention, the care plan should have been updated to reflect that. Further interview with the DON revealed the Quality Assurance (QA) Nurse was responsible for ensuring that the MDS Coordinators, Unit Managers, and nurses were monitoring to ensure that all care plan interventions were being followed.</p> <p>2. A review of the medical record for Resident #12 revealed the resident was admitted to the facility on 10/09/14, with a diagnosis of Acute Renal Failure and with an indwelling urinary catheter.</p> <p>A review of Resident #12's most recent MDS assessment, dated 11/16/14, revealed the facility assessed the resident to have a score of 15 on the BIMS indicating the resident was cognitively intact.</p> <p>A review of Resident #12's care plan revealed staff was required to provide catheter care.</p> <p>An interview conducted with Resident #12 on 12/11/14 at 10:55 AM revealed staff did not ever secure the resident's indwelling urinary catheter while the resident was in the facility, but secured the urinary catheter to the resident's leg when the resident left the building.</p>	F 282		

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F 282	Continued From page 5  An interview conducted with SRNA #4 on 12/11/14 at 12:35 PM revealed the facility's catheter care policy was to notify the resident's nurse if the SRNA observed that a urinary catheter was not secured. The SRNA stated the resident's nurse was responsible for securing the resident's urinary catheter. The SRNA stated she had just performed care "about 30 minutes ago" for Resident #12 and the urinary catheter tubing was secured to the bed at that time. Further interview with SRNA #4 on 12/11/14 at 2:50 PM revealed the SRNA had checked Resident #12's catheter tubing after the interview at 12:35 PM and the tubing was not secured to the resident's thigh or the bed as required.  An interview on 12/11/14 at 12:45 PM with LPN #1 revealed the LPN had not looked at Resident #12's catheter that day, but stated that urinary catheter tubing was usually secured to the bed.  An interview conducted with the DON on 12/11/14 at 4:30 PM, revealed the DON made rounds daily to ensure care was provided to residents in accordance with the facility's urinary catheter care policy. Additional interview revealed the DON was not aware residents' catheters were not being secured by any manner or means to prevent pulling of the catheter tubing. Further interview revealed the facility had "Cath-Secures" in stock that should be used to secure catheters. The DON further stated she was not aware the facility's catheter care policy was not specific or gave no clear guidance as to how a resident's catheter tubing was to be secured.  3. A review of Resident #2's medical record revealed the facility admitted the resident on	F 282			

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F 282	<p>Continued From page 6</p> <p>12/02/13 and the resident had diagnoses that included Dementia, a history of Urinary Tract Infections, and Urinary Retention.</p> <p>A review of the comprehensive care plan dated 09/16/14 revealed the facility developed a care plan to address the use of a urinary catheter for urinary retention with interventions to provide catheter care every shift and as needed.</p> <p>Observations of a skin assessment on 12/10/14 at 1:10 PM revealed Resident #2's indwelling urinary catheter tubing was not secured by any means to prevent pulling of the catheter tubing.</p> <p>An interview conducted with SRNA #1 on 12/11/14 at 12:40 PM, revealed the SRNA provided care to Resident #2 on 12/10/14. According to the SRNA, a "Cath-Secure" was not on the resident because the resident had not had any problems pulling on the catheter.</p> <p>4. A review of Resident #6's medical record revealed the facility admitted the resident on 09/30/14 and had diagnoses that included Multiple Sclerosis and Neurogenic Bladder.</p> <p>A review of the care plan dated 10/31/14 revealed the facility developed a care plan for Resident #6 that addressed the resident's urinary catheter with an intervention to have a "Cath-Secure" in place.</p> <p>Observation of urinary catheter care provided by SRNA #2 on 12/09/14 at 12:55 PM, revealed the resident's urinary catheter tubing was not secured by any manner or means to prevent pulling of the catheter tubing when the SRNA initiated catheter care. In addition, the SRNA did not secure the catheter tubing when catheter care was</p>	F 282		

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F 282	<p>Continued From page 7 completed.</p> <p>An additional observation on 12/10/14 at 11:45 AM, of Resident #8's urinary catheter revealed the catheter was not secured by any manner or means.</p> <p>An interview conducted with SRNA #2 on 12/11/14 at 1:20 PM, revealed the SRNA was not aware of the facility policy for securing the indwelling catheter tubing and was not aware how the catheter tubing was required to be secured to prevent pulling. According to the SRNA, the catheter tubing was secured when the resident's catheter drainage bag was attached to the resident's bed frame.</p> <p>An interview conducted on 12/11/14 at 12:35 PM, with LPN #1 revealed the LPN had conducted an assessment of Resident #3's skin on 12/10/14 at 11:45 AM, and did not notice the resident's catheter was not secured because she did not normally conduct skin assessments. Additional interview revealed that if an SRNA noticed a resident's catheter was not secured, the SRNA should have informed the nurse.</p> <p>5. A review of the medical record for Resident #16 revealed the facility admitted the resident from the hospital on 12/05/14, with an indwelling urinary catheter and with diagnoses that included Hypoxemia, Obesity, and a Chemical Abnormality.</p> <p>Further review of the record revealed the facility developed an admission care plan dated 12/05/14 with interventions to provide catheter care per facility protocol.</p>	F 282			

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F 282	<p>Continued From page B</p> <p>Observation of Resident #16's catheter on 12/11/14 at 10:35 AM revealed no evidence the resident's urinary catheter was secured by any manner or means to prevent pulling/trauma.</p> <p>An interview conducted with SRNA #1 on 12/11/14 at 12:40 PM revealed Resident #16's catheter became unsecured while bathing the resident on 12/11/14, and the SRNA had not informed the resident's nurse so a "Cath-Secure" could be placed back on the resident.</p> <p>6. A review of Resident #6's medical record revealed the facility admitted the resident on 09/30/14, with diagnoses that included Multiple Sclerosis, Neurogenic Bladder, and Anemia. Further review revealed Resident #2 was receiving hospice services and had a history of recurrent pneumonia.</p> <p>A review of the comprehensive care plan for Resident #6 dated 10/31/14 revealed the facility developed a care plan that addressed the resident's respiratory condition related to asthma and congestive obstructive pulmonary disease (COPD) with interventions to administer oxygen as ordered by the physician.</p> <p>A review of Resident #6's December 2014 physician's orders revealed the resident was required to have oxygen at 4 liters per minute via a nasal cannula.</p> <p>Observations of Resident #6 conducted on 12/09/14 at 10:45 AM, 12:55 PM, 2:20 PM, 3:58 PM, and 5:30 PM, and on 12/10/14 at 8:45 AM and 9:40 AM, revealed the facility was administering oxygen to Resident #6 via a nasal cannula at 2 liters per nasal cannula, not at the</p>	F 282		

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F 282	Continued From page 9 physician-ordered 4 liters.  An interview conducted on 12/11/14 at 1:25 PM, with LPN #3 revealed the LPN was not aware Resident #6 had orders for oxygen at 4 liters per minute. The LPN stated the resident's previous order was for oxygen at 2 liters per minute.  An interview with the Unit Manager, RN #1, on 12/11/14 at 1:55 PM revealed she made rounds daily to ensure residents' oxygen was being administered as ordered and had not noticed Resident #6's oxygen was not being administered as required.  An interview with the DON conducted on 12/11/14 at 4:30 PM revealed the DON made rounds daily to ensure care was being provided in accordance with the resident's plan of care. The DON was not aware the residents' catheters were not being secured to prevent pulling of the catheter tubing for Residents #2, #6, #12, and #16. In addition, the DON was not aware Resident #6's oxygen was not being administered as per physician orders.	F 282			
F 315 SS=E	483.25(d) NO CATHETER PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	See attached		

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F 315	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents with indwelling urinary catheters received appropriate treatment and services to restore as much normal bladder function as possible for four (4) of nineteen (19) sampled residents. Observations revealed Residents #2, #8, #12, and #16 had indwelling urinary catheters that were not secured to prevent pulling of the catheter tubing as required by the facility's policy/procedure.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Giving Catheter Care," (undated) revealed a resident's catheter tubing was to be coiled and secured. The policy was not specific regarding the manner or means of securing the catheter tubing. An interview with the Director of Nursing (DON) on 12/11/14 at 4:30 PM revealed catheters should be secured using a Cath-Secure device (a Cath-Secure device is a device used to secure the catheter to a resident's leg to prevent pulling).</p> <p>1. A review of Resident #2's medical record revealed the facility admitted the resident on 12/02/13 with diagnoses that included Dementia and Urinary Retention.</p> <p>A review of the comprehensive Minimum Data Set (MDS) assessment for Resident #2 dated 09/15/14 revealed the facility assessed the resident to require the use of an indwelling urinary catheter due to a diagnosis of urinary retention.</p>	F 315		
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F 315 Continued From page 11

A review of Resident #2's comprehensive care plan dated 09/16/14 revealed the facility developed a care plan to address the use of a urinary catheter for urinary retention with interventions to provide catheter care every shift and as needed.

Observations of a skin assessment on 12/10/14 at 1:10 PM revealed Resident #2's indwelling urinary catheter tubing was not secured by any means to prevent pulling of the catheter tubing.

An interview conducted with State Registered Nurse Aide (SRNA) #1 on 12/11/14 at 12:40 PM, revealed the SRNA provided care to Resident #2 on 12/10/14. According to the SRNA, the resident's "Cath-Secure" was not on the resident because the resident had not had any problems pulling on the catheter.

2. A review of Resident #3's medical record revealed the facility admitted the resident on 09/30/14 with diagnoses that included Multiple Sclerosis, Neurogenic Bladder, and a History of Urinary Tract Infections.

A review of the most recent comprehensive MDS assessment for Resident #3 dated 10/09/14 revealed the resident was assessed to require a urinary catheter related to a diagnosis of Neurogenic Bladder.

A review of the care plan dated 10/31/14 revealed the facility developed a care plan for Resident #3 that addressed the resident's urinary catheter with an intervention to have a "Cath-Secure" in place.

Observation of urinary catheter care provided by

F 315

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F 315	<p>Continued From page 12</p> <p>SRNA #2 on 12/09/14 at 12:55 PM revealed the resident's urinary catheter tubing was not secured by any manner or means to prevent pulling of the catheter tubing when the SRNA initiated catheter care. In addition, the SRNA did not secure the catheter tubing when catheter care was completed.</p> <p>An additional observation on 12/10/14 at 11:45 AM, of Resident #6's urinary catheter revealed the catheter was not secured by any manner or means.</p> <p>An interview conducted with SRNA #2 on 12/11/14 at 1:20 PM, revealed the SRNA was not aware of the facility policy for securing the indwelling catheter tubing and was not aware how the catheter tubing was required to be secured to prevent pulling. According to the SRNA, the catheter tubing was secured when the resident's catheter drainage bag was attached to the resident's bed frame.</p> <p>An interview conducted on 12/11/14 at 12:35 PM, with Licensed Practical Nurse (LPN) #1 revealed the LPN had conducted an assessment of Resident #6's skin on 12/10/14 at 11:45 AM, and did not notice the resident's catheter was not secured because she did not normally conduct skin assessments. Additional interview revealed that if an SRNA noticed a resident's catheter was not secured, the SRNA should have informed the nurse.</p> <p>3. A review of the medical record for Resident #16 revealed the facility admitted the resident from the hospital on 12/05/14, with an indwelling urinary catheter and with diagnoses that included Obesity, Hypoxemia, and a Chemical</p>	F 315			

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F 315	<p>Continued From page 13</p> <p>Abnormality.</p> <p>Further review of the record revealed the facility developed an admission care plan dated 12/05/14 with interventions to provide catheter care per facility protocol.</p> <p>Observation of Resident #16's catheter on 12/11/14 at 10:35 AM revealed no evidence the resident's urinary catheter was secured by any manner or means to prevent pulling/trauma and no evidence a "Cath-Secure" was attached to the resident's catheter tubing.</p> <p>An interview conducted with SRNA #1 on 12/11/14 at 12:40 PM revealed Resident #16's catheter became unsecured while bathing the resident on 12/11/14 and the SRNA had not informed the resident's nurse that the resident's "Cath-Secure" had come off the resident's leg so that it could be replaced.</p> <p>4. A review of the medical record for Resident #12 revealed the resident was admitted to the facility on 10/09/14, with a diagnosis of Acute Renal Failure and with an indwelling urinary catheter.</p> <p>A review of Resident #12's most recent Minimum Data Set (MDS) assessment, dated 11/18/14, revealed the facility assessed the resident to have a score of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact.</p> <p>An interview conducted with Resident #12 on 12/11/14 at 10:55 AM revealed staff had never secured the resident's indwelling urinary catheter while the resident was at the facility. Resident</p>	F 315		
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F 315	<p>Continued From page 14</p> <p>#12 stated facility staff secured the urinary catheter to the resident's leg only when the resident left the building.</p> <p>An interview conducted with SRNA #4 on 12/11/14 at 12:35 PM revealed the facility's catheter care policy was to notify the resident's nurse if the SRNA observed that a urinary catheter was not secured. The SRNA stated the resident's nurse was responsible for securing the resident's urinary catheter. The SRNA stated she had just performed care "about 30 minutes ago" for Resident #12 and the urinary catheter tubing was secured to the bed at that time. Further interview with SRNA #4 on 12/11/14 at 2:50 PM revealed the SRNA had checked Resident #12's catheter tubing after the interview at 12:35 PM and the tubing was not secured to the resident's thigh or the bed as required.</p> <p>An interview on 12/11/14 at 12:45 PM with LPN #1 revealed the LPN had not looked at Resident #12's catheter that day, but stated that urinary catheter tubing was usually secured to the bed.</p> <p>An interview conducted with the DON on 12/11/14 at 4:30 PM, revealed the DON was not aware residents' catheters were not being secured by any manner or means to prevent pulling of the catheter tubing. The DON stated the facility had "Cath-Secures" in stock that should be used to secure residents' urinary catheters. The DON further stated she was not aware the facility's catheter care policy was not specific or gave no clear guidance as to how a resident's catheter tubing was to be secured.</p>	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	See attached	

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F 323	Continued From page 15  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 facility policy review, it was determined the facility failed to ensure residents were free from accident hazards related to side rails not being padded for one (1) of nineteen (19) sampled residents (Resident #10). Review of the comprehensive care plan for Resident #10 dated 04/03/14, revealed a care plan intervention for the resident to have padded side rails. However, the facility failed to ensure that Resident #10 had padded side rails.  The findings include:  Review of facility policy titled "Incident Investigation Policy," undated, revealed the policy did not specifically address ensuring residents were as free from accident hazards as possible.  Observations made on 12/09/14 at 5:30 PM and on 12/10/14 at 4:32 PM revealed Resident #10 did not have padded side rails in place as indicated on the resident's comprehensive care plan.  Review of Resident #10's medical record revealed the facility admitted the resident on	F 323			

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F 323	<p>Continued From page 15</p> <p>12/06/08, with diagnoses that included Senile Dementia with Depressive Features, Contracture of Joint, Senile Osteoporosis, Osteoporosis, Decreased Vision, Body Myoclonic Jerking, Moderate/Severe Cognitive Impairment with Agitation, Debility, Deformity/Contracture of Hip/Knee, Delusion, and Advanced Osteoarthritis.</p> <p>Review of Resident #10's most recent Quarterly Minimum Data Set (MDS) dated 09/28/14, revealed the facility assessed Resident #10 to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated that Resident #10 had severe cognitive impairment.</p> <p>Review of Resident #10's comprehensive care plan dated 04/03/14, revealed the resident had potential for skin breakdown related to impaired mobility, incontinence, poor decision-making, thin fragile skin, and heart disease. Further review of Resident #10's comprehensive care plan revealed an intervention to pad the resident's side rails.</p> <p>Review of Resident #10's Resident Kardex (Certified Nursing Assistant Care Plan), undated, revealed Resident #10 was to have three-quarter bilateral side rails, however, the facility failed to ensure the Nursing Assistant Care Plan included padding for the side rails.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 12/11/14 at 1:28 PM revealed SRNAs were responsible for applying padding to side rails as needed. SRNA #3 stated she had never noticed Resident #10 to have padded side rails in the two years she had worked at the facility, and was not aware that Resident #10 required padded side rails.</p>	F 323			

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F 323	Continued From page 17  Interview with Licensed Practical Nurse (LPN) #4 on 12/11/14 at 1:40 PM revealed she cared for Resident #10 daily and had worked for one year on the hallway where Resident #10 resided. Continued interview with LPN #4 revealed nurses and nurse aides were responsible for ensuring padding was present on resident side rails, but she had not observed Resident #10 to have padded side rails at any time.  Interview with Registered Nurse (RN) #1 on 12/11/14 at 1:55 PM revealed she was the Unit Coordinator for the unit on which Resident #10 resided. She stated staff tried to work as a team to make sure residents' care plans were followed, but she was not aware that Resident #10 required padded side rails. Further interview with RN #1 revealed SRNAs were given any new resident care plan updates during shift report and that interventions should be on the Resident Kardex. She stated nursing staff was responsible for ensuring any new orders for residents were followed and that she conducted rounds twice a day (once in the morning and once in the evening) to ensure care plans were being followed and provided staff education as needed.  Interview with the Medicare MDS Coordinator on 12/11/14 at 1:02 PM and 2:23 PM revealed that the MDS Coordinators were responsible for updating Resident Kardexes and that they were reviewed monthly for accuracy and updated as needed. She further stated she was not aware that Resident #10 was required to have padded side rails.  Interview with the Medicaid MDS Coordinator on 12/11/14 at 3:15 PM revealed she had added the	F 323		

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F 323	Continued From page 18 padded side rails to Resident #10's comprehensive care plan following the resident's annual MDS assessment dated 04/02/14 as a precautionary measure. Continued interview with the Medicaid Coordinator revealed she failed to ensure that the intervention had been added to the Resident Kardex and to ensure that the intervention was implemented as noted on the care plan.  Interview with the Director of Nursing (DON) on 12/11/14 at 4:20 PM revealed she made rounds to ensure that staff was following residents' care plans. She stated rounds were also made by her, the nurses, or the SRNAs every two hours to ensure care plans were being followed. Continued interview with the DON revealed she was not aware that Resident #10 required padded side rails, but she thought Resident #10 may have had padded side rails at some point in the past. The DON stated that if Resident #10 no longer needed the padded side rails intervention, the care plan should have been updated to reflect that. Further interview with the DON revealed the Quality Assurance (QA) Nurse was responsible for ensuring that the MDS Coordinators, Unit Managers, and nurses were monitoring to ensure that all care plan interventions were being followed.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328	See Attached		

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F 328	<p>Continued From page 19</p> <p>Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to administer oxygen at the physician prescribed rate for one (1) of nineteen (19) sampled residents. Resident #6 had physician's orders for oxygen to be administered at 4 liters per minute via nasal canula (a tube that fits in the nostrils to deliver oxygen therapy). The resident's oxygen was observed to be administered at 2 liters per minute on 12/09/14 and 12/10/14.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Special Needs-Respiratory Care," (undated) revealed the purpose of the policy was to ensure residents received any necessary respiratory treatments including oxygen therapy. Further review of the policy revealed that respiratory care in the facility included oxygen and that all treatments should be ordered by the resident's physician.</p> <p>A review of Resident #6's medical record revealed the facility admitted the resident on 09/30/14 with diagnoses that included Multiple Sclerosis and Anemia. Further review revealed Resident #2 was receiving hospice services and had a history of recurrent pneumonia.</p>	F 328			

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F 328	<p>Continued From page 20</p> <p>A review of the comprehensive care plan for Resident #6 dated 10/13/14 revealed the facility developed a care plan that addressed the resident's respiratory condition related to asthma and congestive obstructive pulmonary disease (COPD) with interventions to administer oxygen as ordered by the physician.</p> <p>A review of Resident #6's December 2014 physician's orders revealed the resident was required to have oxygen at 4 liters per minute via nasal cannula.</p> <p>Observations of Resident #6 conducted on 12/09/14 at 10:45 AM, 12:55 PM, 2:20 PM, 3:50 PM, and 5:30 PM, and on 12/10/14 at 8:45 AM and 9:40 AM revealed the facility was administering oxygen to Resident #6 via a nasal cannula at 2 liters per nasal cannula, not at the physician ordered 4 liters.</p> <p>An interview conducted on 12/11/14 at 1:25 PM, with Licensed Practical Nurse (LPN) #3 revealed the LPN was not aware Resident #6 had orders for oxygen at 4 liters per minute. The LPN stated the resident's previous order was for oxygen at 2 liters per minute.</p> <p>An interview with the Unit Manager, Registered Nurse (RN) #1, on 12/11/14 at 1:55 PM revealed she made rounds daily to ensure residents' oxygen was being administered as ordered and had not noticed Resident #6's oxygen was not being administered as required.</p>	F 328			

**F282**

1. Residents #2, #6, #12, and #16 are receiving services in accordance with their written plan of care. Resident #10's care plan has been updated to reflect her current status/care needs.
2. The Administrative Nursing staff reviewed all care plans and made resident care rounds to ensure all services are being provided as indicated for each resident.
3. An inservice was conducted by the Administrator on 1/6/15 with nursing staff (nurses and nurse aides) on the importance of following the care plan and updating promptly to reflect each resident's current status, special attention was focused on ensuring oxygen settings are correct and catheter care is provided per the facility policy. The staff was also inserviced on the importance of being aware of interventions for each resident and ensuring they are in place as ordered.
4. The CQI designee will randomly review five care plans weekly for one month to ensure interventions are in place and accurate then monthly for a quarter. Any irregularities will be corrected immediately and forwarded to the CQI committee for further review and follow up.
5. Completion Date 1/6/15

**F315**

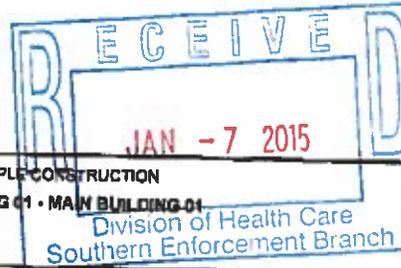
1. Residents #2, 6, 12, and 16 catheters were secured immediately by the nursing staff.
2. All other residents with catheters were assessed by the nursing staff to ensure their catheters were properly secured per the facility policy/procedures.
3. An inservice was conducted by the Administrator on 1/6/15 with the nursing staff regarding providing appropriate care to residents with indwelling urinary catheters. This inservice specifically reviewed the facility policy and procedures for keeping catheters secure so as to prevent the resident from pulling it out.
4. A CQI committee designee will conduct observations to ensure all catheters are secured. These observations will be conducted weekly for one month then monthly for one quarter. Any irregularities will be corrected immediately and forwarded to the CQI committee for further review and follow up.
5. Completion Date: 1/6/15

**F323**

1. Resident #10 was re-assessed by the IDT to determine if side rail pads were needed. After review of medical diagnoses, mobility, status, and interview of direct care staff it was determined that resident was not at risk for injury related to side rail use. Kardex and care plan both were immediately updated.
2. Resident care rounds were completed by the Administrative nursing team to ensure that all interventions were in place to prevent accidents in accordance with each resident's plan of care.
3. An inservice was conducted by the Administrator with the nursing staff including MDS staff on 1/6/15 on the importance regarding maintaining accurate and updated care plans. The inservice also addressed the importance of ensuring all interventions are in place as directed by the care plan to prevent accidents.
4. The CQI designee will review 4 charts per unit including care plans weekly for one month then monthly for one quarter then quarterly. They will also make rounds to ensure interventions are being implemented appropriately as specified in the plan of care. Any irregularities will be corrected immediately and forwarded to the CQI committee for further review and follow up.
5. Completion Date 1/6/15

**F328**

1. Resident #6's oxygen is being administered in accordance with her physicians order.
2. The nursing staff has conducted resident care rounds to ensure all residents treatment and care for special services including oxygen are being provided as ordered by the physician. The rounds include checking all oxygen concentrators settings to ensure they correspond with physicians orders.
3. An inservice was conducted by the Administrator with all nursing staff on 1/6/15 that addressed the importance of administering oxygen in accordance with physicians orders. The nurses were directed to check oxygen settings for accuracy each shift while providing care to the residents.
4. A CQI committee member will conduct observations of four residents with oxygen per unit per week to ensure they are receiving the correct settings as ordered. These observations will be conducted weekly for one month, monthly for one quarter. Any irregularities will be corrected immediately and forwarded to the CQI committee for further review and follow up.
5. Completion Date 1/6/15



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NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822	

(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1978</p> <p>Survey under: NFPA 101 (2000 Edition) Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and resident rooms</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Diesel, installed 2008</p> <p>A standard Life Safety Code survey was conducted on 12/10/14. Knott County Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 90. The facility is licensed for 92 beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire).</p> <p>Deficiencies were cited with the highest</p>	K 000		

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

*Ruby P. Gorman* Administrator

TITLE

(X6) DATE

1-7-15

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.

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

PRINTED: 12/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  12/10/2014
NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822		
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K 000	Continued From page 1 deficiency identified at "D" level.	K 000	<i>See Attached</i>		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire/smoke barrier doors were maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately thirty-four (34) residents. The facility has the capacity for ninety-two (92) beds with a census of ninety-two (92) on the day of the survey.  The findings include:  During the Life Safety Code tour on 12/10/14 at 12:50 PM with the Director of Maintenance (DOM), a set of cross-corridor fire/smoke barrier doors located next to room 108 was observed not to close all the way and left an excessive gap when closed. These doors must close all the way	K 027			

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K 027	<p>Continued From page 2</p> <p>to help prevent fire/smoke from spreading to other parts of the building in case of a fire situation.</p> <p>An interview with the DOM on 12/10/14 at 12:50 PM revealed the gap was approximately 3/8 inch.</p> <p>The findings were revealed to Administration upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.5. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>A.8.3.4.1 The clearance for proper operation of smoke doors is defined as 1/8 in. (0.3 cm). For additional information on the installation of smoke-control door assemblies, see NFPA 105, Recommended Practice for the Installation of Smoke-Control Door Assemblies.</p>	K 027		

**K027**

1. The affected cross corridor fire/smoke barrier door was repaired immediately.
2. All doors throughout the facility have been evaluated by the Maintenance Supervisor and are closing completely with no excessive gap.
3. An inservice was conducted by the Administrator on 1/6/15 with all staff regarding the importance of the fire doors closing properly with no excessive gap. The staff was instructed to notify maintenance at any time they observe any concerns with the fire doors. The maintenance supervisor will make weekly rounds to check fire doors.
4. A CQI committee designee will conduct observations to ensure the doors are closing properly with no excessive gap. These observations will be conducted weekly for one month then monthly for one quarter. Any irregularities will be corrected immediately and forwarded to the CQI committee for further review and follow up.
5. Completion Date 1/6/15