



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

PRINTED: 02/02/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2011	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to notify the physician and responsible party when a change in status occurred for one of nineteen sampled residents. There was no evidence the physician or responsible party was notified when resident #6 sustained a significant weight loss.</p> <p>The findings include:</p> <p>A review of the medical record for resident #6 revealed the resident was admitted to the facility on March 26, 2002, with diagnoses that included Alzheimer's Disease, Hypertension, Congestive Heart Failure, Anxiety, Coronary Artery Disease, Renal Failure, and Diabetes. A review of the weight record for resident #6 revealed the resident's weight was recorded as 200.0 pounds on September 7, 2010. Resident #6 was transferred to the hospital on October 5, 2010, and was readmitted to the facility on October 7, 2010. On October 8, 2010, the resident's weight was recorded as 171.8 pounds. There was no evidence in the medical record the physician or responsible party was notified until October 13, 2010, five days later when a speech therapy evaluation was ordered by the physician.</p> <p>A review of the facility's policy for Changes in a Resident's Condition or Status, dated January 9, 2003, revealed the physician and the responsible party were required to be notified when a change in a resident's status occurred. The policy further stated, "Except in medical emergencies, all other notifications must be made as soon as practical, but in no case shall such notification exceed</p>	F 157	<p>*All resident weights are reviewed each week during the Nutrition at Risk meeting. The MD will be notified of any significant weight changes and staff will act accordingly to his orders. The residents weight will be monitored and discussed each week with interventions until weight is satisfactory.</p> <p>*The Quality Assurance Team will monitor the weight variance report each month to ensure MD notification on variances and facility follows through with orders.</p>	

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F 157	Continued From page 2 twenty-four (24) hours for a change occurring in the resident's condition or status."  Observations of resident #6 on January 17, 2011, at 5:00 p.m., revealed the resident was feeding her/himself a pureed diet with honey-thickened liquids with assistance from staff. An interview with the Restorative Nurse Aide (RNA) conducted on January 18, 2011, at 2:40 p.m., revealed the RNA was responsible for obtaining resident weights. The RNA stated that whenever a resident's weight was very different from the previous weight, he/she notified the charge nurse and the Director of Nursing right away.  An interview conducted with the Director of Nursing (DON) on January 18, 2011, at 3:00 p.m., revealed the DON did not notify the physician or the Registered Dietician (RD) when the resident returned from the hospital. The DON stated prior to the resident's hospitalization the RD had made a recommendation to discontinue fortified oats and supplements to encourage weight loss for resident #6. The DON also stated resident #6 was discussed in the Nutrition at Risk meeting on October 8, 2010, but no notifications were made to the physician, responsible party, or RD.	F 157		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide services according to professional standards for four	F 281	F281 *Resident #10 had a xray of knee at facility without MD order on record. This resident had no adverse effects as a result of this def practice. Resident # 2 was given medications that were crushed in a pill crusher bag. A small amount of medication was left in the plastic pill crusher sleeve. The record of resident #2 was reviewed and	2/14/11

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F 281	<p>Continued From page 3</p> <p>residents (residents #2, #3, #4, and #10) of nineteen sampled residents. Resident #10 received a portable x-ray of the right knee; however, there was no evidence the facility had obtained a physician's order prior to the x-ray. Residents #2 and #3 received liquid/crushed medications per gastrostomy tube (G/T); however, the nurse failed to rinse the medication containers to ensure the residents received the correct dosage as prescribed by the physician. In addition, resident #4 had physician's orders for a restorative plan of care; however, there was no evidence this was being provided for the resident.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy on Physician's Orders (dated January 9, 2003) revealed all verbal orders must be counter-signed by the ordering physician within seven days of the receipt of the telephone order, or upon the physician's next scheduled visit, whichever is sooner.</li> </ol> <p>Record review revealed resident #10 was admitted to the facility on August 3, 2010, with the following diagnoses: Congestive Heart Failure, Renal Insufficiency, Hypertension, Hyperlipidemia, Peptic Ulcer Disease, Rheumatoid Arthritis, Anemia, Chronic Gastroparesis, Compression Fracture T-11, T-12, L-1, L-3, and Constipation. Further record review revealed nursing notes on December 22, 2010, documenting the resident's right knee with a "trace of screw coming out of skin. Had total knee replacement eight to ten years ago." According to the nurse's notes the resident's physician was contacted and the physician "stated to order x-rays." The nurse further</p>	F 281	<p>no adverse effects to the resident was noted from the above. Resident #3 was given medication through their G tube. The nurse failed to rinse the medication cup to ensure all medications in the cup went into the G tube. The record of resident #3 was reviewed and no adverse effects to the resident was noted. Resident #4 was ordered to be on a restorative dining program. The restorative nurse aide was not made aware of this order. The residents weight has remained stable and no adverse affects to the resident was noted.</p> <p>*All residents who receive mobile xrays, receive medications, and are on restorative dining have the potential to be affected.</p> <p>*A nursing inservice on 2-3-11 informed all nursing staff of the facility policy of obtaining mobile xray orders. They were also informed on the proper medication administration procedure when giving Gtube medications and when using pill crusher bags. The restorative nurse was conference on 2-3-11 on the importance of attending all restorative meetings and adding new residents as MD orders.</p> <p>*The Quality Assurance Committee will review records of residents who receive mobile xrays to assure proper MD orders for procedure. The Quality Assurance Committee will do a monthly medication pass audit to ensure that meds are administered according to good nursing</p>

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F 281	<p>Continued From page 4</p> <p>documented that Mobile X-Ray was notified of the order. A report of the right knee x-ray was dated December 22, 2010. However, review of the medical record revealed no evidence of a written physician's order for an x-ray of the resident's right knee.</p> <p>An interview with the facility's Director of Nursing on January 19, 2011, at 3:15 p.m., revealed an in-service on the subject of writing physician's orders was provided to nursing staff in November 2010. The Director of Nursing further indicated he/she had later reinforced with the nurses the importance of following through and writing physician's orders when received.</p> <p>An interview with the nurse who received the physician's order on December 22, 2010, revealed the nurse voiced being unaware that it was the nurse's responsibility to write an order for x-rays if the x-ray was performed at the facility. The nurse explained orders were written if the resident left the facility. Further interview revealed the nurse had been present in the in-service concerning writing physician's orders in November 2010.</p> <p>2. A review of the medical record revealed resident #2 had a physician's order to receive Lasix 40 milligrams (mg) daily and Oxycodone 325 mg every six hours per G/T. A medication administration observation conducted on January 18, 2011, at 11:20 a.m., revealed the staff nurse obtained the two medications for resident #2 and crushed the medications separately in a plastic sleeve. The staff nurse was then observed to pour the crushed medications from the plastic sleeve into an asepto syringe filled with water and administer the medications per G/T to resident</p>	F 281	<p>standards. The Quality Assurance Committee will review restorative dining notes each month to ensure that all residents with orders to be on restorative dining program are receiving services.</p>	

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F 281	<p>Continued From page 5</p> <p>#2. However, further observations of the plastic sleeves revealed a small amount of white powder was left in the plastic sleeve.</p> <p>An interview conducted with the facility nurse on January 18, 2011, at 11:50 a.m., revealed the nurse stated he/she had never been instructed to rinse the plastic sleeve to ensure the resident received all of the medications.</p> <p>An interview conducted with the Director of Nurses (DON) on January 19, 2011, at 11:15 a.m., revealed the DON had never considered rinsing the plastic sleeve to ensure the entire dosage of medication was administered to the resident. The DON observed the powder substance that remained in the plastic sleeves after the medications for resident #2 had been crushed. The DON agreed that some of the medications had been left in the plastic sleeve.</p> <p>A review of the facility policy/procedure related to Medication Administration (no date) revealed medications are to be administered as prescribed in accordance with good nursing principles. The policy/procedure further revealed when medications were required to be crushed for administration a device specific for crushing medications was required to be used. The policy/procedure noted for residents who are able to take medications orally, the medications should be ground coarsely and mixed with the appropriate substance so the entire dosage of medication is received by the resident. The policy/procedure related to crushing medications for G/T administration only noted that the medications were required to be crushed finely to prevent clogging of the G/T; the policy failed to address how the staff would ensure the entire</p>	F 281			

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F 281	<p>Continued From page 6 dosage was administered to the resident.</p> <p>3. A review of the medical record revealed resident #3 had a physician's order to receive Dilantin 100 mg three times a day. During the medication administration observation conducted on January 17, 2011, the facility nurse was observed to obtain a bottle of Dilantin Suspension labeled 125 mg/5 ml. The nurse was observed to draw up 4 milliliters of the Dilantin Suspension with a syringe, place the medication into a plastic medication cup, and administer the medication to resident #3 per G/T. However, after pouring the liquid medication into the asepto syringe filled with water, a small amount of the liquid medication still remained in the plastic medication cup. The nurse failed to rinse the medication cup to ensure resident #3 received the prescribed dosage of medication.</p> <p>Further review of the medical record revealed a Dilantin level was ordered to be obtained every six months. A review of the laboratory tests dated July 23, 2010, revealed the Dilantin level was 12.9 ug/mL with a reference range of 10.0-20.0 ug/mL.</p> <p>An interview conducted with the staff nurse on January 17, 2011, at 3:30 p.m., revealed the staff nurse had never been instructed to rinse the plastic medication cup to ensure the entire dosage of medication was administered to the resident.</p> <p>An interview conducted with the Director of Nurses (DON) on January 19, 2011, at 11:15 a.m., revealed the DON had never considered rinsing the plastic medication cup to ensure the entire dosage of medication was being administered to the resident.</p>	F 281		

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F 281	Continued From page 7  A review of the facility policy/procedure related to Medication Administration (no date) revealed medications are to be administered as prescribed in accordance with good nursing principles. The policy/procedure related to administration of liquid medications noted the correct device was required to be utilized to allow for accurate measurement of doses of liquid medication requiring precise measurements.  4. A review of the Restorative Nursing Care Protocol (no date given) revealed Restorative Programs were to be carried out by State Registered Nurse Aides who have been trained in restorative techniques and supervised by a licensed nurse. In addition, when done in group settings, there will be one State Registered Nurse Aide per every four residents receiving the Restorative Program. A periodic evaluation of the resident's progress was to be completed by the licensed nurse and found in the clinical record.  A review of the medical record for resident #4 revealed the resident was admitted to the facility on October 28, 2010, with diagnoses that included Dementia, Arteriosclerotic Heart Disease, Gastroesophageal Reflux Disease, Depression Hypertension, and Osteoarthritis. Further review of the medical record revealed the resident had a physician's order dated December 14, 2010, for Restorative Nursing Feeding Program.  Observations of resident #4 on January 17, 2011, at 4:50 to 5:15 p.m., revealed the resident in the dining room feeding her/himself supper following tray setup by staff. The resident consumed 90 percent of supper. On January 18, 2011, at 12:00	F 281			

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F 281	<p>Continued From page 8</p> <p>p.m., the resident was observed to feed her/himself without cueing/prompting and consumed 100 percent of lunch.</p> <p>An interview conducted with the Restorative State Registered Nurse Aide (RSRNA) on January 18, 2011, at 12:05 p.m., revealed resident #4 was not receiving restorative dining services. According to the RSRNA there were already four residents in the Restorative Dining Program and resident #4 was not included. The RSRNA further stated the Director of Nursing (DON) supervised the Restorative Programs and the RSRNA reported to the DON regarding progress of residents in the program.</p> <p>An interview with the DON conducted on January 18, 2011, at 4:15 p.m., revealed the resident had been identified as sustaining a weight loss and staff believed resident #4 would benefit from the Restorative Nursing Dining Program. The physician ordered the program for the resident and the DON stated she revised the care plan to include restorative dining. However, according to the DON, she failed to communicate with the RSRNA and resident #4 was not included in the Restorative Dining Program. The DON stated resident #4's weight has remained stable. The DON further stated the residents receiving restorative services were reviewed weekly and she failed to realize resident #4 was not included.</p>	F 281		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312	<p>F312</p> <p>*Resident #3 had their nails cut by nursing when this was brought to their attention. No adverse affects to the resident was noted.</p> <p>*All diabetic residents have the potential to be affected by the def practice. All diabetic residents were checked for nails care.</p> <p>*A nursing inservice on 2-3-11 informed all RN's, LPN's, and nurse aides on the facility policy of on diabetic nail care.</p>	2/4/11

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F 312	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming and hygiene for one of nineteen sampled residents. Resident #3 was observed to have long fingernails with a dark brown substance noted underneath the resident's nails for two consecutive days during the survey.</p> <p>The findings include:</p> <p>Resident #3 was observed on January 17, 2011, at 1:40 p.m., 3:30 p.m., and 4:30 p.m., to be lying abed. The resident's fingernails were observed to be long with a dark brown substance underneath the resident's fingernails. Further observations conducted on January 18, 2011, at 9:00 a.m., 10:40 a.m., 12:15 p.m., and 1:15 p.m., revealed the resident's fingernails continued to be long with a dark brown substance underneath the resident's fingernails.</p> <p>A review of the medical record revealed resident #3 was admitted to the facility on April 9, 2007, with diagnoses of Diabetes Mellitus, Cerebrovascular Accident (CVA) with right hemiparesis, Chronic Atrial Fibrillation, Hypertension, and Dementia. A review of the annual comprehensive assessment conducted on February 25, 2010, and the quarterly assessment conducted on November 11, 2010, revealed resident #3 was assessed to require total assistance of staff for personal hygiene and bathing needs.</p>	F 312	<p>*The Quality Assurance Committee will review nail care on diabetic residents each month to ensure compliance with facility policy.</p>	

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F 312	<p>Continued From page 10</p> <p>A review of the comprehensive care plan for resident #3 revealed the facility identified a problem related to bathing/hygiene deficit with interventions to include: clean and check the resident's fingernails and toenails daily. A review of the Nurse Aide assignment sheet revealed nail care was to be provided for resident #3 by the licensed nurse.</p> <p>An interview conducted with the nurse aide on January 18, 2011, at 2:30 p.m., revealed the licensed nurse was responsible for providing nail care to the diabetic residents.</p> <p>An interview conducted with the licensed nurse on January 18, 2011, at 12:45 p.m., revealed the nurse was responsible for providing nail care for the diabetic residents. The nurse stated there was no routine schedule for providing diabetic nail care and the nail care was not documented in the resident's medical record. The nurse stated the resident's nails were required to be checked at least monthly and trimmed/cleaned as needed. The nurse stated he/she had not checked resident #3's fingernails for "awhile."</p> <p>A review of the facility's policy/procedure related to Nail Care (no date) revealed, "some institutions do not allow nurses to cut resident's nails if the resident had diabetes mellitus, peripheral vascular disease, or a localized condition such as a fungus infection." The policy/procedure did not define who would be required to provide nail care for diabetic residents.</p> <p>An interview conducted with the DON on January 19, 2011, at 11:15 a.m., revealed the licensed nurses are required to observe the residents' fingernails daily and to provide diabetic nail care</p>	F 312		

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F 312	Continued From page 11 as needed for the diabetic residents. The DON stated the nail care should be documented in the nurse's notes when diabetic nail care had been provided. The DON further stated he/she had not monitored the diabetic residents to ensure nail care was being provided as needed for these residents.	F 312		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that one of nineteen sampled residents was provided with services to maintain body weight. Resident #6 had been identified to have risk factors related to alterations in nutrition and a care plan was developed by the facility, however when the resident sustained a twenty-eight pound/fourteen percent weight loss in one month there was no evidence the facility altered treatment to address the resident's weight loss.  The findings include:	F 325	F325 *Resident #6 weight went from 200 to 171 during a 2 month period. She is currently at a stable weight. No adverse effects was noted as a result of her weight fluctuation.  *All residents were reviewed for significant weight change. All residents that were found to have weight change had an altered treatment plan to address their altered nutrition.  *All residents with a significant weight change will be reviewed at the Nutritionally at Risk meeting each week. Facility policy for these residents will be followed accordingly. These residents will be reviewed each week and followed until stable weight is achieved.  *The Quality Assurance Committee will review residents with significant weight changes once a month and ensure that facility weight policy is followed.	2/14/11

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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
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F 325	<p>Continued From page 12</p> <p>A review of the Unintended Weight Loss Policy Statement (dated January 10, 2003) revealed the Director of Nursing (DON), the Dietary Manager (DM), and the Registered Dietitian (RD) would review any weight loss of five percent or greater in a month, or ten percent or greater up to 180 days. The policy further stated a determination would be made as to whether the weight loss was avoidable or unavoidable and the resident would be assessed for appropriate interventions, would be continually monitored/evaluated, and the resident's care plan would be evaluated and revised based on appropriate interventions.</p> <p>A review of the Nutrition at Risk (NAR) Weight Loss Protocol (no date given) revealed if a resident sustained an unplanned weight loss of five percent or more in one month's time the resident would be placed on weekly weight monitoring. Further interventions included in the NAR program consisted of interventions tailored to the resident's individual needs, RD evaluation and follow-up, weekly review by the NAR with detailed progress notes, communication with the physician, and the resident and responsible party would be kept informed of the resident's progress.</p> <p>A review of the medical record for resident #6 revealed the resident was admitted to the facility on March 26, 2002, with diagnoses that included Alzheimer's Dementia, Hypertension, Anxiety, Diabetes, Renal Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. The facility assessed the resident to be at risk for alteration in nutrition and a care plan was developed to address the resident's weight loss potential. Further review of resident #6's medical record revealed the physician had</p>	F 325		

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F 325	<p>Continued From page 13</p> <p>ordered a puree diet for the resident on September 29, 2010. A review of the resident's weight history revealed the resident weighed 200.2 pounds on June 7, 2010, 198.2 pounds on July 6, 2010, 200.5 pounds on August 2, 2010, 200.00 pounds on September 7, 2010, and 171.8 pounds on October 8, 2010. There was no evidence the resident's physician or the RD was notified of the 28-pound/14 percent weight loss in one month. The resident was placed on the NAR; however, there was no evidence of weekly weight monitoring or any new care plan interventions except a speech therapy referral initiated on October 13, 2010.</p> <p>An interview with the DON conducted on January 18, 2011, at 3:00 p.m., revealed the DON was aware of the resident's weight loss, however, the fortified oats and protein supplement had been discontinued in September 2010 and the DON stated the resident was on a planned weight loss program. The DON further stated the facility was monitoring the resident once monthly in the NAR meetings, however no new interventions were initiated until December 10, 2010, except a referral to the speech therapist on October 13, 2010. The DON also stated resident #6's weight has been stable since October and the resident has not sustained any further weight loss.</p> <p>Observations of resident #6 on January 17, 2011, at 5:00 p.m. revealed the resident was feeding her/himself a pureed diet with honey-thickened liquids with assistance from staff.</p>	F 325		
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive</p>	F 364	<p>F364 *Resident #17 refused her dinner tray and a nurse aide put the tray back on the food carrier without marking the tray refused. Another nurse aide attempted to feed the</p>	2-14-11

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F 364	<p>Continued From page 14</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide foods that were palatable and at the proper temperature for one of nineteen sampled residents.</p> <p>The findings include:</p> <p>Observation of the evening meal on January 17, 2011, revealed an open food cart was delivered to the 400 Hall at 4:38 p.m. Further observation revealed the last tray was removed/offered to resident #17 at 5:00 p.m. The resident refused the tray and the CNA was observed to place the tray back onto the open food cart. The resident's food tray was observed to continue to sit on the food cart until the evening meal service was completed at 5:25 p.m. At 5:28 p.m., another CNA was observed to remove resident #17's food tray from the open cart and prepared to offer the resident the same tray that had been on the cart for approximately 50 minutes. The tray was intercepted and a temperature and palatability test was conducted of the food tray with facility staff.</p> <p>The temperature of the chicken and dumplings was 84 degrees Fahrenheit and tasted cold, the mashed potatoes were 80 degrees Fahrenheit and tasted cold, the applesauce was 58 degrees Fahrenheit and tasted cool, and the juice was 60 degrees Fahrenheit and tasted warm.</p>	F 364	<p>food to the resident at a later time not knowing the tray had been refused and was cold. The resident received a new tray after this was brought to the attention of the nurse aide. No adverse effects to the resident was noted.</p> <p>*All resident who receive a food tray have the potential to be affected by the def practice.</p> <p>*An inservice on 2-3-11 made staff aware of the facility policy on tray refusal.</p> <p>*The Quality Assurance Committee will do a quarterly food service audit to ensure that food trays are received according to policy.</p>	

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F 364	Continued From page 15 Resident #17 was not interviewable.  An interview conducted with the CNA on January 17, 2011, at 5:40 p.m., revealed the CNA was not aware the tray had previously been offered to resident #17. The CNA stated he/she had observed the tray sitting on the open cart and believed the resident had not been fed. The CNA stated he/she did not know how long the tray had been sitting on the cart.  An interview conducted with the Dietary Manager (DM) on January 17, 2011, at 5:40 p.m., revealed the tray should have been returned to the kitchen after resident #17 refused the tray. The DM stated the trays should be served to the resident within 10 minutes after arrival to each unit.  An interview conducted with the DON on January 19, 2011, at 11:15 a.m., revealed trays were to be passed to the residents within 20 minutes.  A review of the facility policy/procedure related to Food Service (no date) revealed resident trays would be distributed to the residents by nursing personnel promptly after the trays arrived on the unit.	F 364		
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 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 *The expired specimen tubes were destroyed and new tubes were obtained. No residents were found to have been affected by the def practice.  *All residents who receive lab services have the potential to be affected. All labs supplies were checked to ensure expiration dates were valid. No other labs supplies were affected.  *The DON will review lab supplies each month to ensure expiration dates are in compliance.	2-11

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F 431	<p>Continued From page 16</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 and interview, the facility failed to assure that out-of-date drugs and biologicals were not available for resident use. Observations in the medication room revealed specimen collection supplies were out-of-date and available for resident use.</p> <p>The findings include:</p> <p>Observation on January 19, 2011, at 4:00 p.m., revealed the medication room contained out-of-date laboratory supplies available for</p>	F 431	<p>*The Quality Assurance Committee will do a quarterly review on lab supplies to ensure expiration date are in compliance.</p>	

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F 431	Continued From page 17 resident use. Twenty-seven Anaerobic culture tubes were stored in a cabinet in the medication room. One tube expired November 2009, one tube expired July 2010, and 25 tubes expired October 2010.  An interview with the Registered Nurse (RN) conducted on January 19, 2011, at 4:00 p.m., revealed the facility staff was responsible for obtaining laboratory specimens and when supplies were needed staff notified the laboratory to replenish the supply.	F 431			
F-465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Extremely dusty heating/air conditioning units were observed in twenty resident rooms. Walls in seven resident rooms were observed to be soiled and contained scarred markings from objects scraping the walls. Observations in resident rooms 201, 206, and 407 revealed door frames with areas of chipped paint and a bedside table in resident room 102 was missing the trim on the edges. Geri-chairs were observed to be torn and ragged. The medication carts were observed to be soiled.  The findings include:	F 465	F465 *The rooms that had been identified have been painted and all repairs have been made to the rooms and the front grills were replaced on the air units. The med carts were cleaned and all Geri chairs were assessed and repairs made as necessary. No residents were found to have been affected by def practice.  *All resident rooms were surveyed for any needed repairs. All residents living at the facility have the potential to be affected by the practice.  *The facility hired a full time maintenance man on 11-19-10. The facility had been without a maintenance man for the past 3 months. The new maintenance supervisor is currently completing a back log of repairs created by the vacancy in the position.  *The Quality Assurance Committee will do a quarterly review on facility maintenance to ensure that standards are met.	2-14-11	

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F 465	<p>Continued From page 18</p> <p>Observations of the facility on January 18, 2011, at 3:00 p.m., and on January 19, 2011, at 4:00 p.m., revealed the following areas were in need of maintenance/housekeeping services:</p> <ol style="list-style-type: none"> <li>1. The heating/air conditioning units in resident rooms 101, 102, 103, 104, 105, 107, 108, 109, 110, 202, 204, 205, 208, 303, 306, 307, 403, 404, 406, and 407 were observed to have a heavy coating of dust.</li> <li>2. The door frames in resident rooms 201, 206, and 207 were observed to have missing areas of paint.</li> <li>3. Resident rooms 207, 303, 304, 305, 401, 402, and 407 were observed to have areas on the walls that were soiled and marred from objects scraping against them.</li> <li>4. A bedside table in resident room 102 was missing the trim around the edge and had an exposed, rough area where the trim should have been.</li> <li>5. Geri-chairs in resident rooms 207 and 304 were observed to have torn/ragged arms.</li> <li>6. Three medication carts in the medication room were observed to be soiled. Pill residue, soil, and a red sticky substance were observed in/on all three medication carts. An interview conducted with the Registered Nurse (RN) at 4:00 p.m. on January 19, 2011, revealed the night shift Certified Medication Technicians (CMTs) were assigned to clean the med carts each night. The RN further stated that he/she was unaware if the carts were monitored to ensure cleanliness.</li> </ol>	F 465			

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F 465	Continued From page 19	F 465			
F 502 SS=D	An interview conducted with the Maintenance Supervisor and the Housekeeping Supervisor on January 18, 2011, at 3:00 p.m., revealed the supervisors made random rounds to monitor for areas in need of repair/cleaning. The Maintenance Supervisor stated he had changed the filters in the heating/air conditioning units, but had not gotten around to all of them. 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY	F 502	F502 *Residents #3 had Hemoglobin A1C lab test completed. The test came back within range. The resident had no adverse effects from the missed lab test.	2-14-11	
	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure lab results were obtained as ordered by the physician for one of nineteen sampled residents. Resident #3 had a physician's order for a Hemoglobin A1C to be obtained every six months; however, there was no evidence the lab test had been obtained since June 2010.  The findings include:  A review of the medical record revealed resident #3 was admitted to the facility on April 9, 2007, with diagnoses to include Diabetes Mellitus Type II. A review of the January 2011 physician's orders revealed the physician had ordered a Hemoglobin A1C (Hgb A1C) to be obtained every six months.		*All residents had their clinical record reviewed to ensure that no ordered labs were missed. All residents that receive lab services have the potential to be affected by the practice.  *The charge nurse will review orders before each shift and verify that if a resident has a lab order then a lab requisition has been filled out. The charge nurse will also verify that the lab representative has received lab requisitions.  *The Quality Assurance Committee will do a quarterly review on facility lab requisitions to ensure that all labs are obtained as ordered.		

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F 502	<p>Continued From page 20</p> <p>A review of the laboratory reports for resident #3 revealed the most recent lab report for an Hgb A1C was obtained on June 24, 2010. However, there was no evidence the lab test had been performed in December 2010.</p> <p>An interview conducted with the DON on January 17, 2011, at 3:50 p.m., revealed the physician-ordered lab tests were entered into the facility's computer system. The DON stated he/she was responsible for completing the lab test requests and to check the lab test reports to ensure all lab tests were conducted timely and as ordered by the resident's physician. The DON stated the Hgb A1C had not been obtained as ordered because the DON believed the test had been conducted during a recent hospital stay for resident #3. However, the DON stated a review of the hospital labs revealed the Hgb A1C had not been performed and had been missed by the facility.</p> <p>A review of the facility's policy/procedure related to Lab Tests (dated November 2, 2007) revealed the lab tests would be noted on the lab calendar by the nurse who received the physician's order and a lab requisition would be completed daily by the Medical Records staff. The policy/procedure further noted a copy of the lab requisition would be maintained in a notebook at the nurse's station until the lab test results were returned and reported to the resident's attending physician.</p>	F 502			

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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on January 19, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.