

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2010
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all employees were screened through the Kentucky Nurse Aide Abuse Registry as required. A review of five (5) recently hired employees revealed the facility failed to check the Nurse Aide Abuse Registry for two (2) of the five (5) records reviewed.</p> <p>The findings include:</p> <p>A review of employee records revealed two high school students were trained on March 25, 2010, to be paid feeding assistants. Both employees' records revealed criminal background and reference checks were completed; however, there was no evidence the Nurse Aide Abuse Registry had been checked.</p> <p>An interview with the facility's program coordinator at 3:15 p.m. on March 31, 2010, revealed the facility conducted reference and criminal background checks but did not conduct Nurse Aide Abuse Registry checks. The coordinator stated he/she was unaware that Nurse Aide Abuse Registry checks were required since the employees were co-op students from the local school.</p>	F 225	<p>Effective immediately, any students being trained and working through the High School co-op program or other programs will be treated as a regular employee and will be sent to the Human Resources Coordinator to complete the reference check, criminal background check and the Nurse Aide Abuse Registry, prior to allowing them to begin training.</p> <p>The Human Resources Coordinator and the Supervisor of the Department in which a student is being trained will complete a check off list together prior to allowing a student to begin training to ensure that the Nurse Aide Abuse Registry has been contacted along with the Criminal Background check and references.</p>	04/21/10	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	F 276			

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F 276	<p>Continued From page 2</p> <p>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess and act on the results of the assessment for one (1) of twenty (20) sampled residents. The facility failed to investigate causative factors and factors that needed to be considered related to an assessed decline in continence for resident #6 following two (2) quarterly assessments.</p> <p>The findings include:</p> <p>Observations of resident #6 on March 30, 2010, at 8:55 a.m., revealed the resident to be in the dining room feeding him/herself breakfast following tray setup by staff. Resident #6 was awake, alert, and enjoying breakfast.</p> <p>A review of the medical record for resident #6 revealed the resident was admitted to the facility on June 18, 2009, with diagnoses that included Atrial Fibrillation, Congestive Heart Failure, Constipation, Dementia, Depression, Gastroesophageal Reflux Disease, Hypertension, Hypothyroidism, Dysphagia, Cerebrovascular Accident, and Gout. A comprehensive Minimum Data Set (MDS) admission assessment completed by the facility on June 30, 2009, revealed resident #6 was assessed to be continent of bladder. A quarterly MDS assessment completed on September 23, 2009,</p>	F 276	<p>A quarterly MDS was completed on resident #6 on 3/23/10. CareTracker Bladder Detail Report was run and a new Bladder Assessment was completed on resident #6 on 4/3/10 which is consistent with the most recent MDS information for continence status of this resident. In addition, a 3-Day Elimination Diary was completed 3/31-4/2. Based on information obtained from the diary and assessment, the resident has now been placed on an individualized toileting schedule to address his/her decline in continence.</p> <p>Resident will be reassessed at least quarterly with an OBRA assessment. LPN in charge of the Bowel & Bladder program will review/reassess at least quarterly or with notification of improvement/decline in continence status according to facility policy, using facility Bladder Assessment and/or Bladder Management Plan Review. Along with assessment information, documentation from CareTracker Bladder Detail report will be used to monitor improvement/decline. If decline is noted, a new 3-Day Elimination Diary will be completed and causative factors reviewed.</p> <p>LPN in charge of the Bowel & Bladder program will use Quality Indicator report to review other residents listed as occasionally or frequently incontinent without a toileting program. Any resident who does not have a 3-Day Elimination Diary which is current, according to facility policy, will have one completed by 4/20/2010 and an individualized toileting program developed if appropriate to restore or maintain as much normal function as possible.</p>	

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F 276	<p>Continued From page 3</p> <p>assessed resident #6 to have experienced a decline in continence. The quarterly assessment revealed the resident was occasionally incontinent of bladder and incontinent of bowel less than weekly. The following quarterly MDS assessment completed on December 23, 2009, revealed the resident had further declined in continence to being frequently incontinent of bladder and occasionally incontinent of bowel. An additional bowel/bladder assessment completed by the LPN on December 22, 2009, revealed the resident was assessed to have both functional and urge incontinence; however, there was no indication these problems were addressed.</p> <p>According to the facility's policy regarding continence/incontinence, all residents will have a bowel/bladder assessment upon admission, annually, and with a significant change in continence. Any resident assessed as having incontinence of bladder and/or bowel is evaluated for appropriate services to restore or maintain as much normal function as possible. There was no evidence resident #6 was further assessed regarding the decline in continence nor was any type of toileting program initiated.</p> <p>An interview with the MDS Coordinator conducted on March 30, 2010, at 12:00 p.m., revealed the MDS staff utilized the "care tracker" completed by the direct care staff to determine a resident's continence status. A second interview with the MDS staff conducted on March 31, 2010, at 9:30 a.m., revealed bowel/bladder assessments were also completed by a Licensed Practical Nurse (LPN) quarterly following the MDS assessment.</p> <p>An interview with the LPN conducted on March 30, 2010, at 12:20 p.m., revealed the LPN did not</p>	F 276	<p>The LPN will begin using the CareTracker Bladder Detail report to assist in completing all Bladder Assessments and Bladder Reviews. The MDS staff will review the Bladder Assessment and CareTracker Bladder Detail report prior to completing the MDS and report any inconsistencies to the LPN in charge of the Bowel and Bladder program.</p> <p>On 4/12/10 our corporate consultant inserviced the MDS Coordinator and LPN in charge of Bowel and Bladder Program regarding facility policy and procedure for assessment and review using Bowel and Bladder Assessment, Bladder Management Plan Review and 3-Day Elimination Diary.</p> <p>The Corporate Consultant will do random audits of Bladder Assessments as well as corresponding Elimination Diaries and MDS's monthly over the next three months to ensure assessments are being completed accurately and causative factors are being reviewed for incontinent residents.</p> <p>This information will be reviewed by the Quality Assurance Committee for compliance monthly.</p> <p>04/21/10</p>

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F 276	Continued From page 4 utilize the care tracker in completing resident #6's bowel/bladder assessment. The LPN stated that he/she usually just asked the direct care staff on the day shift when he/she saw them. The LPN further stated he/she had not received training regarding bowel/bladder assessments. The LPN also stated he/she did not consult with the MDS staff regarding the assessments and did not participate in care planning conferences.	F 276		
F 279 SS=D	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). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan based on findings from	F 279	A care plan has now been developed to address the toileting needs of resident #6 related to her decline in continence. The care plan will be reviewed by MDS staff and LPN in charge of Bowel and Bladder program at least quarterly and updated as needed based on assessment information as well as reported improvement/decline indicated by staff and CareTracker documentation. LPN in charge of the Bowel & Bladder program will use Quality Indicator report to review other residents listed as occasionally or frequently incontinent without a toileting program. Any resident who does not have a 3-Day Elimination Diary which is current, according to facility policy, will have one completed by 4/20/2010 and an individualized toileting program developed if appropriate to restore or maintain as much normal function as possible. A care plan will be developed/updated to include interventions to address causative factors derived from further assessment. Care plans will be reviewed at least quarterly by MDS staff as well as LPN in charge of the Bowel and Bladder program to ensure residents' needs are being addressed related to continence status.	

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F 279	Continued From page 5 the assessment for one (1) of twenty (20) sampled residents. Resident #6 experienced a decline in continence; however, no care plan was developed to address the resident's toileting needs or to restore bladder functioning. The findings include: Observations of resident #6 on March 30, 2010, at 8:55 a.m., revealed the resident to be in the dining room feeding him/herself breakfast following tray setup by staff. Resident #6 was awake, alert, and communicating with staff. A review of the medical record for resident #6 revealed the resident was admitted to the facility on June 18, 2009, with diagnoses that included Atrial Fibrillation, Congestive Heart Failure, Constipation, Dementia, Depression, Gastroesophageal Reflux Disease, Hypertension, Hypothyroidism, Dysphagia, Cerebrovascular Accident, and Gout. A comprehensive Minimum Data Set (MDS) admission assessment completed by the facility on June 30, 2009, revealed resident #6 was assessed to be continent of bladder and bowel. A quarterly MDS assessment completed on September 23, 2009, assessed resident #6 to be occasionally incontinent of bladder and incontinent of bowel less than weekly. A quarterly MDS assessment completed on December 23, 2009, revealed the resident had declined in continence to being frequently incontinent of bladder and occasionally incontinent of bowel. An additional bowel/bladder assessment completed by the LPN on December 22, 2009, revealed the resident was assessed to have both functional and urge incontinence; however, there was no	F 279	The Corporate Consultant will do random audits of Bladder Assessments as well as corresponding Elimination Diaries, MDS's and care plans monthly over the next three months to ensure assessments are being completed accurately, causative factors are being reviewed for incontinent residents and care plans being developed/updated appropriately. The Corporate Consultant will be submit a report to the Quality Assurance Committee monthly for review.	04/21/10

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F 279	Continued From page 6 indication these problems were addressed. According to the facility's policy regarding continence/incontinence, all residents will have a bowel/bladder assessment upon admission, annually, and with a significant change in continence. Any resident assessed as having incontinence of bladder and/or bowel is evaluated for appropriate services to restore or maintain as much normal function as possible. There was no evidence resident #6 was further assessed regarding the decline in continence nor was a care plan developed to address resident #6's incontinence. An interview with the MDS staff conducted on March 31, 2010, at 9:30 a.m., revealed the MDS staff and the Licensed Practical Nurse (LPN), who was responsible for bowel/bladder assessments, should have developed a care plan to address the decline in continence; however, no care plan was developed. An interview with the LPN conducted on March 30, 2010, at 12:20 p.m., revealed the LPN did not recall why he/she had not recommended a toileting plan when the quarterly bladder/bowel assessment was completed.	F 279		
F 281 SS=D	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, interview, and record review, the facility failed to follow the physician's	F 281	Current physician orders for resident #6 indicate "No Thin Liquids", "Pureed Diet with Nectar Thick Liquids". The facility continues to maintain a folder in the dining room to communicate special dining needs for resident #6 as well as other residents with special dining needs. In addition, the facility maintains an SRNA Care Plan on each individual resident to communicate individual needs. The Director of Nursing in serviced SRNA #1 on 03/30/2010 regarding the folder in the dining room to communicate special dining needs for resident #6 as well as other residents and reminded of the importance of referring to the communication folder prior to meals.	

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F 281	<p>Continued From page 7</p> <p>orders for one (1) of twenty (20) sampled residents. Resident #6 had physician's orders for "no thin liquids"; however on March 30, 2010, staff was observed to serve regular water to resident #6.</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 June 18, 2009, with diagnoses that included Atrial Fibrillation, Congestive Heart Failure, Constipation, Dementia, Depression, Gastroesophageal Reflux Disease, Hypertension, Hypothyroidism, Dysphagia, Cerebrovascular Accident, and Gout. A review of the physician's orders dated October 2009 revealed a physician's order for "No Thin Liquids" for resident #6.</p> <p>Observation in the dining room on March 30, 2010, at 1:15 p.m., EDST, revealed resident #6 was served regular water by facility staff.</p> <p>An interview with State Registered Nursing Assistant (SRNA) #1 and SRNA #2 at 1:22 p.m. on March 30, 2010, revealed the facility maintains a folder in the dining room to communicate special dining needs for residents. A review of the folder revealed resident #6 was to receive thickened liquids. SRNA #1 stated even though the folder indicated thickened liquids, the speech therapist had told staff resident #6 could have regular water prior to the meal if the resident requested it.</p> <p>An interview with the Speech/Language Pathologist (SLP) conducted on March 30, 2010, at 5:00 p.m., revealed resident #6 had been permitted to have thin liquids in the past, but that</p>	F 281	<p>The Administrator and Director of Nursing inserviced all other SRNA's caring for resident #6 and other residents with special dining needs were inserviced on 03/30-03/31/10 regarding checking the Resident's SRNA care plan and the folder in the dining room prior to meals to ensure that all residents who have physician orders for thickened liquids are not served thin liquids.</p> <p>Licensed Nurses were inserviced 4/21/10 regarding communication of physician orders to SRNA's both verbally and thru the SRNA worksheet and dining room folder in regards to special dining needs including orders for thickened liquids.</p> <p>All residents receiving thickened liquids were observed by Administrator and DON during meal service on 4/3/2010 to ensure that they were receiving only thickened liquids according to physician orders. On 04/03/2010 and again on 04/21/2010 the Licensed nurses were instructed to spot check residents during meal service on an ongoing basis to ensure that they are receiving the proper consistency of liquids according to physician orders.</p> <p>A team of Administrative staff has been assigned to monitor meal service randomly and to ensure that those residents who are to receive only thickened liquids according to physician orders are in fact receiving the appropriate consistency and report back to Quality Assurance Committee immediately of any areas of concern.</p>	04/21/10

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F 281	<p>Continued From page 8</p> <p>In October 2009 the order was changed to thickened liquids only. The SLP further stated the recommendation was written in a communication book to Nursing, who was responsible for making direct care staff aware of changes.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator conducted at 5:00 p.m. on March 30, 2010, revealed that nurses were not required to monitor the direct care staff during meals. The coordinator further stated the direct care staff had care plans and a folder in the dining room to ensure they were aware of special needs.</p> <p>An interview with the first floor Registered Nurse (RN) conducted on March 30, 2010, at 1:20 p.m., revealed no licensed staff was responsible to monitor the dining room to ensure physician's orders were followed.</p>	F 281		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate treatment to restore as much bladder function as</p>	F 315	<p>A quarterly MDS was completed on resident #6 on 3/23/10. CareTracker Bladder Detail Report was run and a new Bladder Assessment was completed on resident #6 on 4/3/10 which is consistent with the most recent MDS information for continence status of this resident. In addition, a 3-Day Elimination Diary was completed 3/31-4/2. Based on information obtained from the diary and assessment, the resident has now been placed on an individualized toileting schedule to address her decline in continence and restore as much bladder function as possible.</p>	

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F 315	<p>Continued From page 9</p> <p>possible for one (1) of twenty (20) sampled residents. Resident #6 was assessed to have experienced a decline in continence. There was no evidence that interventions were implemented and/or a toileting program was initiated for resident #6 to restore as much bladder function as possible.</p> <p>The findings include:</p> <p>Observations of resident #6 on March 30, 2010, at 855 a.m., revealed the resident to be in the dining room feeding him/herself breakfast following tray setup by staff. Resident #6 was awake, alert, and communicating with staff.</p> <p>A review of the medical record for resident #6 revealed the resident was admitted to the facility on June 18, 2009, with diagnoses that included Atrial Fibrillation, Congestive Heart Failure, Constipation, Dementia, Depression, Gastroesophageal Reflux Disease, Hypertension, Hypothyroidism, Dysphagia, Cerebrovascular Accident, and Gout. A comprehensive Minimum Data Set (MDS) admission assessment completed by the facility on June 30, 2009, revealed resident #6 was assessed to be continent of bladder and bowel. A quarterly MDS assessment completed on September 23, 2009, assessed resident #6 to be occasionally incontinent of bladder and incontinent of bowel less than weekly. A quarterly MDS assessment completed on December 23, 2009, revealed the resident had declined in continence to being frequently incontinent of bladder and occasionally incontinent of bowel. An additional bowel/bladder assessment completed by a Licensed Practical Nurse (LPN) on December 22, 2009, revealed the resident was assessed to have both functional</p>	F 315	<p>Resident #6 will be reassessed at least quarterly with an OBRA assessment. LPN in charge of the Bowel & Bladder program will review/reassess at least quarterly or with notification of improvement/decline in continence status according to facility policy, using facility Bladder Assessment and/or Bladder Management Plan Review. Along with assessment information, documentation from CareTracker Bladder Detail report will be used to monitor improvement/decline. If decline is noted, a new 3-Day Elimination Diary will be completed and causative factors reviewed and toileting schedule adjusted as appropriate to meet her individual needs in an attempt to restore as much bladder function as possible.</p> <p>LPN in charge of the Bowel & Bladder program will use Quality Indicator report to review other residents listed as occasionally or frequently incontinent without a toileting program. Any resident who does not have a 3-Day Elimination Diary which is current, according to facility policy, will have one completed by 04/20/2010 and an individualized toileting program developed if appropriate to restore or maintain as much normal function as possible.</p> <p>The LPN will begin using the CareTracker Bladder Detail report to assist in completing all Bladder Assessments and Bladder Reviews. The MDS staff will review the Bladder Assessment and CareTracker Bladder Detail report prior to completing the MDS and report any inconsistencies to the LPN in charge of the Bowel and Bladder program in order to assist in identifying residents who might benefit from toileting schedule or other interventions to restore bladder function.</p>	

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F 315	Continued From page 10 and urge incontinence; however, there was no evidence these problems were addressed or any toileting program was developed for resident #6. According to the facility's policy regarding continence/incontinence, all residents will have a bowel/bladder assessment upon admission, annually, and with a significant change in continence. Any resident assessed as having incontinence of bladder and/or bowel is evaluated for appropriate services to restore or maintain as much normal function as possible. There was no evidence resident #6 was further assessed regarding the decline in continence nor was a care plan initiated to address resident #6's incontinence and attempt to restore as much bladder function as possible. An interview conducted with the LPN on March 30, 2010, at 12:20 p.m., revealed the LPN talked with direct care staff to determine resident #6's continence status. The LPN stated the resident was aware of the urge to urinate, but was unable to get to the toilet quickly enough. The LPN further stated he/she could not recall why he/she did not further assess resident #6 and initiate a toileting plan. An interview conducted with the MDS staff on March 31, 2010, at 9:30 a.m., revealed the resident should have had a care plan developed to address resident #6's decline in continence; however, that was not done.	F 315	On 4/12/10 our corporate consultant inserviced the MDS Coordinator and LPN in charge of Bowel and Bladder Program regarding facility policy and procedure for assessment and review using Bowel and Bladder Assessment, Bladder Management Plan Review and 3-Day Elimination Diary. The Corporate Consultant will do random audits of Bladder Assessments as well as corresponding Elimination Diaries and MDS's monthly over the next three months to ensure assessments are being completed accurately, causative factors are being reviewed and incontinent residents are placed on individualized toileting schedules as appropriate. The Corporate Consultant will provide a report of completed audit to the Quality Assurance Committee.	04/21/10
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	F 441	Summit Manor has established and maintained an Infection Control Program designed to provide a safe, sanitary and comfortable environment that will help to prevent the development and transmission of disease and infection.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
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F 441	<p>Continued From page 11 to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</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, the facility failed to maintain an Infection Control Program to provide a safe, sanitary, and</p>	F 441	<p>The Medication Aide observed to obtain ice from the cooler for a resident's use and placed the scoop back into the ice was conferenced on 03/30/10 by the Administrator, regarding our policy to place the ice scoop in the designated holder on side of the cart to prevent the transmission of infection.</p> <p>Per the request of the surveyor, the house keeper dumped the ice in the cooler, cleaned the ice cooler and the scoop, placed the scoop in the designated holder and returned to passing ice on 03/30/10.</p> <p>The Fluids at Bedside Policy was reviewed and revised to include when passing ice the ice scoop must be kept in the designated holder and not placed in the ice to prevent transmission of infection on 04/01/10.</p> <p>The Administrator in-serviced the nursing staff and housekeeping staff on 03/31/10 regarding proper procedure when passing ice or obtaining ice from the cooler to ensure that the scoop is not left in the ice but rather in the designated holder to prevent the transmission of infection.</p> <p>During the nurses meeting on 04/21/10, the Administrator instructed the nurses were instructed to observe the ice pass to ensure that the ice scoop is in it's designated holder and not placed in the ice to prevent the transmission of infection.</p> <p>The Quality Assurance Committee met on 04/21/2010 and assigned the Housekeeping Supervisor, the DON and Administrator to conduct weekly random checks to ensure that the staff is following procedures to keep the ice scoop in it's designated holder and not left in the ice and report any areas of concern back to the Quality Assurance Committee.</p>	04/21/10

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F 441	Continued From page 12 comfortable environment to help prevent the development and transmission of disease and infection. Facility staff failed to pass ice under sanitary conditions on March 30, 2010. The findings include: Observation of a first floor East hall ice pass conducted on March 30, 2010, at 4:10 p.m., revealed an ice scoop was observed stored in an ice cooler with the handle in contact with the ice. A Medication Technician was observed to obtain ice from a cooler for resident use and place the scoop back into the ice with the handle in contact with the ice. Further observation revealed that a housekeeper attempted to pass ice to residents after the ice was in contact with the scoop handle until interrupted by the surveyor. An interview conducted with the housekeeper on March 30, 2010, at 4:10 p.m., revealed that the ice scoop was to be stored in the scoop holder and the scoop handle was not supposed to be in contact with the ice. A review of the Fluids at Beside Policy and Procedure dated February 16, 2000, did not address storage of the ice scoop when passing ice to residents.	F 441		
F 465 SS=B	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	F 465	F465 Summit Manor will provide a safe functional sanitary and comfortable environment for residents, staff and the public. Summit Manor is currently in the process of completing a new addition to the therapy department and we have contracted to do a major renovation of the facility including replacement of all windows, re-constructing the nurses stations, replacement of the ceiling tiles, handrails, removal of wallpaper and painting all resident rooms, hallways and the exterior building to be completed by July 2010. The maintenance department will remove remaining wallpaper and paint scard and chipped areas on the East and West halls prior to 05/01/2010. The maintenance department repaired and painted the head of the resident's bed in room #214 and the bathroom in resident room #116 on 04/15/10.	

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F 465	<p>Continued From page 13</p> <p>by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour on March 31, 2010, at 10:00 a.m., revealed the following items were in need of repair:</p> <ul style="list-style-type: none"> - Paint was scarred and chipped on the first floor East hall. - Paint was discolored and the wallpaper border was missing on the first floor West hall. - Room 214 had scarred and chipped paint at the head of the resident's bed. - Drywall was chipped and discolored in the bath in resident room 116. - A positioner pad for resident #12 was torn. - A shower chair seatbelt was observed soiled in the bath in resident room 116. <p>An interview conducted with the Maintenance Supervisor on March 31, 2010, at 10:00 a.m., revealed maintenance logs were maintained at the nurses' stations to identify items in need of repair; the Maintenance Director was not aware of the items in need of repair.</p> <p>An interview conducted with a Registered Nurse (RN) on March 31, 2010, at 5:00 p.m., revealed nurse aides were required to clean the shower chair after each resident use. The RN was not aware why the chair had not been cleaned.</p>	F 465	<p>A new positioned pad for Resident #12 was ordered and replaced on 04/06/10.</p> <p>The shower chair seatbelt in resident's room #116 was soaked in bleach water, laundered and replaced on 03/31/10. The nursing assistant who used the shower chair in room #116 was conferenced by the Administrator for not sending the seat belt to be laundered.</p> <p>The Administrator reminded the SRNA's and Housekeeping Department on 04/01/10 to observe all positioning devices, shower chairs, equipment, resident's rooms and hallways for cleanliness and repairs or replacement daily and to report any needs immediately to the DON's secretary for replacement, to the Maintenance Department for repair or to the laundry to be cleaned.</p> <p>The Housekeeping Supervisor, Maintenance Director, Director of Nursing and Administrator will alternate making rounds and weekly to observe needed repairs, cleaning of equipment and or replacement of items utilized by the Residents.</p> <p>The Quality Assurance Committee met on 04/21/10 to review deficiencies cited, made recommendations to include new monitoring form to be completed monthly, "Are You Ready For Company", which includes a check list consisting of an evaluation of the building for appearance, cleanliness, need for repairs, observation of Residents comfort and dignity. This form will be completed by assigned staff members and/or family members and submitted to the Quality Assurance Committee monthly for review.</p>	04/21/10

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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE AND ZIP CODE 400 BOWMAN BLVD COLUMBIA, KY 42728
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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on March 30, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards in two (2) areas of the facility. The findings include: During the Life Safety Code tour on March 30, 2010, at 9:20 a.m., with the Director of Maintenance, 52 E size oxygen cylinder tanks	K 076	Summit Manor will ensure that the Life Safety Code is being enforced and that no combustible items will be placed within five feet of oxygen cylinders. All combustible items were removed from the oxygen storage room in the downstairs storage room on 03/30/10. The Administrator checked the second floor oxygen room to ensure that no combustible items were stored within five feet of oxygen cylinders on 03/30/10. The Administrator in-serviced the nursing staff and the therapy department immediately regarding storage of combustible items being stored within five feet of oxygen cylinders on 03/30/10. During the nurses meeting held on 04/21/10, the Administrator reviewed the deficiency cited on 03/30/10 with regard to storing combustible items within five feet of oxygen cylinders. The staff were instructed to ensure that no supplies were left in combustible boxes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Brenda Williams* TITLE *Administrator* (X6) DATE *4/22/2010*

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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K 076	Continued From page 1 were noted to be stored in a small closet in the first floor corridor area. Additionally, 24 E size oxygen cylinder tanks were noted to be stored in a closet in the downstairs corridor. These tanks were within five feet of combustible storage. Oxygen cylinders must be kept five feet from combustibles. An interview revealed the Director of Maintenance was not aware of this requirement. Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems	K 076	The eleven to seven shift Nursing Supervisors have been assigned to check the oxygen storage room nightly to ensure that no combustible items are stored within five feet of oxygen cylinders and sign and date corresponding tracking form. The Administrator instructed the oxygen supplier on 04/1/10 not to leave any combustible items in the storage room. The Quality Assurance nurse will check the oxygen storage rooms weekly to ensure that the oxygen cylinders are not within five feet of combustible items and report monthly to the Quality Assurance Committee.	04/21/10