

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

PRINTED: 05/06/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2011
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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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F 000	INITIAL COMMENTS An annual survey was conducted on 04/19/11 through 04/22/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "G".	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F157 SS=G <u>Criteria # 1</u> – How will corrective action be accomplished for: 1) Resident # 2 - On 4/25/11, the DON provided the physician for Resident # 2 a complete summary of all skin issues currently identified. - On 4/25/11, the Wound Nurse reviewed the current treatment plan to assure all areas were included and updated the care plan. - Attachments # 1, 2 & 3 – Note changes on Attachment 3 as follows: Clean with Normal Saline. Apply Normal Saline moist to dry dressing. Apply ABD, wrap with Kerlix, change every shift. 2) Resident # 4 - On 4/22/11 an incident investigation was completed by the DON for the identified areas (brown scabbed area and the bruised area) - The physician for Resident # 4 was notified of the bruised area and scabbed area via phone call by the Clinical Charge RN (Attachment # 4) - The comprehensive care plan for "At Risk for Impaired Skin Integrity" was updated by the Wound Nurse for Resident # 4 on 4/22/11 (Attachment # 5 – the updated areas are:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bucky Jagers, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/8/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and facility policy and procedure, it was determined the facility failed to notify the physician of changes in status for two residents, (#2 & #4)), in the selected sample of ten (10) residents. The facility failed to notify the physician of the deterioration of Resident #2's skin tear, which resulted in an unstageable pressure wound. On 10/24/10, Resident #2 sustained a skin tear to the posterior left lower leg. The physician was notified per a fax from the nurse and an order for treatment was obtained. Additionally, on 11/15/10, another fax for a change in treatment was sent to the physician; however, after 11/15/10 and until 12/20/10, the physician was not notified regarding the deteriorating skin tear, which resulted in an unstageable pressure wound. Additionally, the physician was not notified about Resident #4's brown area on the second toe of the left foot, which measured 0.5 centimeters (cm) x 0.3 cm, and a nickle-sized dark purple discoloration with surrounding light purple discoloration, which was discovered during a skin assessment on 04/21/11.</p> <p>The findings include:</p> <p>A review of the facility's policy "Skin Impairment," revised 02/01/11, revealed the physician shall be notified for awareness of the skin impairment and confirmation of the treatment plan and any</p>	F 157	<p>Care Plan in place for impaired skin integrity related to #1 scab to top of second toe on left foot, #2 bruise to left heel/ankle area, with interventions to leave open to air, and monitor every shift. Monitor area/site for edema, dressing, redness every shift. C.N.A. to monitor skin daily and notify Charge Nurse of any new areas.)</p> <p>- The TAR was updated by the Wound Nurse on 4/22/11 to include treatment plan for the brown scabbed area (Attachment # 6 – the updated areas are: Monitor scab on second toe left foot and bruise to left ankle and heel every shift.)</p> <p><u>Criteria # 2 - How will facility identify other residents:</u></p> <p>1) By 5/13/11 all residents were assessed for skin issues by the DON and the Wound Nurse. A summary of this total assessment was completed. (Attachment # 7) Physicians were notified if indicated; however, there were no bruises of unknown origin, no unknown pressure areas or new skin tears found.</p> <p>2) By 5/13/11 all resident care plans were updated by DON and Wound Nurse to include time frame for notification of physician regarding changes in skin issues. (Attachment # 8 – sample of the care plan with the circled area indicating the update)</p> <p><u>Criteria # 3 - Measures put in place to assure deficient practice will not recur:</u></p>		

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F 157	<p>Continued From page 2</p> <p>non-healing/declining skin impairment or area of concern may referred to the Long Term Care skin team for more in-depth evaluation and recommendations. The policy did not address a defined time frame for physician notification related to deterioration of the wound status or the need for an alternate treatment.</p> <p>1. A record review revealed Resident #2 was admitted to the facility on 08/08/06 with diagnoses to include Pressure Ulcers (coccyx, both hips, right upper back and left lower leg), Osteoporosis, Cardiopulmonary Disease (COPD), Gastroesophageal Reflux Disease (GERD), Hypertension, Dementia, Depression, Anxiety and History of Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 02/20/11, revealed the facility assessed the resident's cognition to be severely impaired, incontinent of bowel and had an indwelling urinary catheter. The facility assessed the resident as being totally dependent for mobility and activities of daily living and at risk to develop pressure ulcers.</p> <p>A review of a physician's fax form, dated 10/24/10 at 12:00 PM, revealed notification of two minor skin tears, with current actions as follows: areas cleansed with normal saline, Vaseline Petroleum applied, covered with 2 x 2 gauze and wrapped with Kerlix. Change daily and as needed (prn). The fax was sent by Licansed Practical Nurse (LPN) #4.</p> <p>A review of a physician's order, dated 10/24/10 at 4:00 PM, revealed an order to clean the skin tear</p>	F 157	<p>1) Policy on "Skin Impairment" was reviewed and updated by the MDS Coordinator on 5/12/11 to include the time frame for notification to the physician related to deterioration of the wound status or the need for alternating treatment. (Attachment # 9 - See circled sections marked 'added')</p> <p>2) Policy on "Notification to Physician" was reviewed and updated by the DON on 5/12/11 to include a time frame for notification of any issue related to changes with the resident. (Attachment # 10 - see circled section marked 'added')</p> <p>3) Comprehensive care plan for "At Risk for Impaired Skin Integrity" was modified by the MDS Coordinator on 4/25/11 to include information related to physician notification. (Attachment # 8) Intervention was added to "notify physician immediately of any decline in skin impairment." (See circled section - marked 'added')</p> <p>4) In servicing was completed with all staff by the Staff Development Coordinator to train and update on following issues: Skin Assessment, Monitoring, Notification and Care Planning. The outline for this training (Attachment # 11) and the sign-in logs (Attachments # 12) for verification of training are included. - All in servicing was completed by 5/19/11.</p> <p><u>Criteria # 4</u> - Monitor performance to ensure solutions are sustained:</p>		

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F 157	<p>Continued From page 3</p> <p>on the back side of the left lower leg with normal saline, apply Vaseline and cover with 2 x 2 gauze and wrap with Kerlix gauze daily and prn.</p> <p>A review of the "Long Term Care Wound Observation" documentation, dated 10/24/10 at 5:40 PM, revealed Registered Nurse (RN) #5 documented a skin tear on the posterior left lower leg, with a small amount of serosanguinous drainage and redness in the center. No measurement was documented.</p> <p>A review of a nurse's note, dated 10/24/10 at 7:13 PM, revealed LPN #4 documented two skin tears on the left lower leg were reported by a nurse aide during morning care. One was on the left posterior lower extremity and one was on the inner right side. The areas were cleansed with normal saline, Vaseline applied, covered with 2 x 2 gauze and wrapped with Kerlix.</p> <p>On 10/28/10 at 11:45 AM, RN #2 documented an observation of the skin tear and noted blood-tinged drainage with a small amount of green drainage. There was no documented evidence of physician notification.</p> <p>On 11/04/10 at 2:23 PM, Licensed Practical Nurse (LPN) #6 documented an observation of the skin tear and noted blood-tinged drainage. There was no documented evidence of physician notification.</p> <p>On 11/11/10 at 3:05 PM, LPN #6 documented an observation of the skin tear and noted yellow/green drainage. There was no documented evidence of physician notification.</p>	F 157	<p>1) On 5/1/11 the worksheet used previously by the DON was expanded by the DON to monitor all incidents related to investigations for skin issues (Attachment # 13)</p> <ul style="list-style-type: none"> - This will be completed by the DON concurrently with each skin incident and a summary will be provided monthly by the DON in a report to the staff at the scheduled monthly staff meeting. - This is an expanded review of skin issues that has been completed by the DON previously and it will be on-going. <p>2) Current monitoring of skin issues will continue as previously in the QA process (by the DON) and will include a section to assure notification of physician regarding changes to any skin area.</p> <p>3) Monitoring will be completed and reported monthly by the DON to all LTC staff and quarterly to the QA committee.</p> <ul style="list-style-type: none"> - The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO. <p><u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11</p>	5/20/11	

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F 157	<p>Continued From page 4</p> <p>On 11/15/10 at 10:30 AM, LPN #3 (Wound Nurse), documented the skin tear with minimal green drainage and the skin flap was missing. There was dark pink tissue in the center with pink surrounding edges. The treatment was changed to clean the wound with normal saline, apply Visco paste loosely, cover with Kerlix, secure with paper tape and change every five days and as needed (prn). A notification of the change in treatment was faxed to the attending physician on 11/15/10 by LPN #3; however, there was no documented evidence of a physician's order, dated 11/15/10. Additionally, a review of the TAR, dated November 2010, revealed there was no documented evidence of the change in treatment until 11/25/10. Documentation on the November and December 2010 TARs revealed the treatment ordered for every five days and as needed (prn) was completed on 11/25/10, 11/30/10, 12/05/10, 12/10/10, 12/15/10 and 12/20/10.</p> <p>A review of nurse's notes, dated 12/20/10 at 3:24 PM, revealed LPN #3 (Wound Nurse), documented that "upon dressing change to the left lower leg, the wound showed great decline, and was no longer a skin tear but an unstageable / pressure ulcer." She described the tissue in the wound base as consisting of 100% yellow slough against a bony prominence. She measured the wound as 12.7 cm x 2.0 cm and was unable to determine the depth due to the yellow slough. On 12/20/10, no time indicated, an order from the attending physician revealed to consult with the Wound Care physician. The nurse revealed the physician (Wound Care Specialist) was notified for consultation.</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>An observation, on 04/20/11 at 2:00 PM, revealed wound care was provided and wound measurements were completed by LPN #3, (Wound Nurse). She was accompanied by other members of the Wound Care Team which included the Director Of Nursing (DON), the Clinical Care Coordinator and the Registered Dietician. The wound on the back of the left lower leg measured 10.6 cm long x 0.5 cm wide, with a depth of 0.8 cm. LPN #3, (Wound Nurse) stated the wound started out as a skin tear and progressed to an unstageable wound. She was unable to provide an explanation of how or why this occurred.</p> <p>An interview with LPN #3 (Wound Nurse), on 04/21/11 at 9:55 AM, revealed the wound initially presented as a skin tear and the treatment was changed because the skin tear was not healing. She stated the wound became worse after the new treatment was initiated. Further interview at 3:45 PM, revealed the new treatment was tried for a while to see if it would work. She was off for a couple of days in December, and when she returned to work, the wound had changed drastically. She stated she did weekly wound assessments and the nurses on the unit did the weekly skin assessments. If the nurses noticed a change in the wound status, they should notify the physician for a treatment change or contact her. Continued interview at 6:30 PM, revealed if there was no documentation, then she did not have any communication with the physician. She stated blood-tinged or yellow/green drainage was something the physician should be notified about, but she was unable to explain why physician notification did not occur. She stated the physician should be notified whenever a wound</p>	F 157			

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F 157	<p>Continued From page 6 changes for the worse.</p> <p>An interview with RN #2 (Charge Nurse), on 04/22/11 at 10:00 AM, revealed she did admission skin assessments and wound care occasionally. She stated she expected the nurses to notify her to collaborate on skin concerns and that any nurse could contact a physician with concerns. She stated that the nurse doing a skin assessment should remove the dressings to assess the wounds, and if the wound declined, the physician should be notified.</p> <p>An interview with Resident #2's physician, on 04/21/11 at 2:00 PM, revealed she usually consulted with a wound surgeon regarding wounds. She stated she was notified about the resident's skin tear on 10/24/10 and about a change in treatment on 11/15/10, but did not recall any other communication with staff, related to the skin tear, until contacted on 12/20/10. She gave the order to refer the resident for consult with the wound surgeon related to his/her wounds. The resident's physician stated she expected to be notified if the wound became worse. Further interview, on 04/22/11 at 11:10 AM, revealed if she had been notified of the worsening of the skin tear sooner, she would have taken action and consulted with the wound surgeon sooner and also referred the resident to Physical Therapy for a wound management program. The physician stated the green drainage may have indicated the presence of infection, but this could only be confirmed by a culture.</p> <p>An interview with the DON, on 04/22/11 at 3:20 PM, revealed nurses on the unit did weekly skin</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>assessments and looked at the wounds depending on the treatment. She stated the nurses usually did not take off dressings because the Wound Nurse did wound treatments daily and the Wound Team did weekly rounds on Wednesday. She stated when a nurse observed a change in a wound, she expected the physician to be notified.</p> <p>An interview with the Administrator, on 04/22/11 at 2:15 PM, revealed the staff did not follow the facility's process related to monitoring the skin tear and notification of the physician in order to prevent the decline in the wound.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 02/02/09 with diagnosis to include History of Deep Vein Thrombosis and Peripheral Neuropathy.</p> <p>Reviews of the annual Minimum Data Set (MDS), dated 12/06/10, and the quarterly MDS, dated 03/06/11, revealed the facility assessed the resident to be cognitively intact and required total assistance with bed mobility.</p> <p>A review of the comprehensive care plan for "At Risk for Impaired Skin Integrity," dated 12/10/10, revealed no information related to physician notification.</p> <p>A review of the "Skin Assessments", dated 03/01/11, 03/08/11, 03/15/11, 03/22/11, 03/29/11 04/05/11, 04/12/11, and 04/19/11, revealed no documentation related to the resident's second toe on the left foot or the bruising on the left outer ankle.</p>	F 157			

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F 157	Continued From page 8 An observation of a skin assessment, on 04/21/11 at 1:30 PM, revealed Resident #4 had a brown area on the second toe of the left foot. The area measured 0.5 centimeters (cm) in length x 0.3 cm width. The brown area was dry, with redness around the perimeter. The resident's outer left ankle had a "nickle-sized" bruise that appeared dark purple in color, with generalized bruising above the nickle-sized area, which was light purple in color. An interview with Licensed Practical Nurse (LPN) #6, on 04/21/11 at 1:30 PM, revealed she completed the resident's skin assessment on 04/19/11; however she did not notice the brown area on the second toe of the resident's left foot. She was unable to provide any information about the bruising on the resident's left ankle. She revealed the bruising should be documented with an investigation report completed. The area on the left second toe was not "open", and should be documented to monitor the area. Further interview with LPN #6, on 04/22/11 at 11:20 AM, revealed she did not document the skin assessment performed on 04/21/11 due to the fact she assessed the resident's skin on 04/19/11 and did not know she was supposed to document the 04/21/11 information. She revealed she informed Registered Nurse (RN) #1 about the area on the resident's left second toe and the bruising on the outer ankle. LPN #6 stated, "We do not call the physician unless we find something major. I did not notify the physician because the area was minor." She revealed the area on the resident's toe looked like there was a scab on it and the scab was ready to fall off.	F 157			

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F 157	Continued From page 9 An interview with RN #1, on 04/22/11 at 11:40 AM, revealed she had not received any report of skin breakdown or bruising related to Resident #4. She revealed it would be the responsibility of the nurse taking care of the resident to document and notify the physician. An interview with the Director of Nursing (DON), on 04/22/11 at 2:40 PM, revealed the area on the resident's left second toe should be measured and documented as a "brown scabbed area that was unstageable." She revealed the bruising should be measured and documented on an investigation report to determine the cause of the bruise. The DON indicated she expected the nurse to notify the physician of both skin issues.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	<u>F164 SS=D</u> <u>Criteria # 1</u> - How will corrective action be accomplished for: 1) Resident # 9 – On 4/25/11, an email was sent by the Staff Development Coordinator regarding privacy treatment for all residents to include Resident # 9 (Attachment # 14) 2) Resident # 2 – On 4/25/11, an email was sent by the Staff Development Coordinator regarding privacy treatment for all residents to include resident # 2 (Attachment # 14) 3) Resident # 6 – On 4/25/11, an email was sent by the Staff Development Coordinator regarding privacy treatment for all residents to include resident # 6 (Attachment # 14)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2011
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346	
(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 164	<p>Continued From page 10</p> <p>resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to provide personal privacy for two residents (#6 & #9), in the selected sample of ten (10) residents. Resident #6 was being toileted and the Director of Nursing (DON) entered the room without knocking on the door and the resident was exposed. Resident #9 was having a skin assessment completed and the staff did not pull the privacy curtain.</p> <p>The findings include:</p> <p>1. A record review revealed Resident #9 was admitted to the facility on 04/08/11 with diagnoses to include Hypertension, Dementia and Cerebral Vascular Accident.</p> <p>A review of the admission Minimum Data Set (MDS, dated 04/19/11, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of "6" which indicated the resident was severely impaired in his/her cognition.</p> <p>An observation, on 04/22/11 at 1:55 PM, revealed</p>	F 164	<p>4) Attachment # 15 lists and verifies all LTC Staff acknowledgement of receiving and opening this email</p> <ul style="list-style-type: none"> - Please note the "Acknowledged" column which means staff opened and read. - If marked transferred, staff sent it to a different box for further review - If mark deleted, staff read email and removed it from their mailbox - If left blank – see comments written by Nursing Home Administrator <p>5) A post test was administered by the Staff Development Coordinator to all LTC staff to ensure the staff understands the provision of privacy. Results were satisfactory compliance by all staff with staff passing the post test as of 6/3/11.</p> <p><u>Criteria # 2</u> - How will facility identify other residents:</p> <p>1) All residents in the facility are automatically identified as having the potential to be affected by this deficient practice since every resident has the right to personal privacy at all times.</p> <p><u>Criteria # 3</u> - Measures put in place to assure deficient practice will not recur:</p> <p>1) Email sent on 4/25/11 to all staff (Attachment # 14)</p> <p>2) Attachment # 15 lists and verifies all LTC Staff acknowledgement of receiving and opening this email</p> <ul style="list-style-type: none"> - Please note the "Acknowledged" column which means staff opened and read. 	

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346	
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F 164	<p>Continued From page 11</p> <p>Two Licensed Practical Nurses (LPNs) were completing a head to toe skin assessment on Resident #9. The privacy curtain was not utilized, and the resident was in direct view of the door. Certified Nurse Aide (CNA) #2 entered the room and was able to visualize the resident's back and buttocks from the door.</p> <p>An interview with LPN #1, on 04/22/11 at 3:05 PM, revealed she was in the room assisting LPN #5 with the skin assessment. She stated there was no other resident in the room at the time and thought closing the door was enough privacy for the task. LPN #1 revealed she should have pulled the curtain to provide privacy for the resident during the skin assessment. She stated "that was my fault for not pulling the curtain because when the aide came in the room, Resident #9 was exposed."</p> <p>An interview the DON, on 04/22/11 at 3:20 PM, revealed she expected the privacy curtains to be pulled when staff provided care to a resident. She stated the curtains should be pulled even if the roommate was not in the room at the time staff provided care. The resident would not be exposed when someone entered the room.</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 03/25/11 with diagnoses to include Debility, Anxiety and Depressive Disorder.</p> <p>A review of the admission Minimum Data Set (MDS), dated 04/04/11, revealed the resident to be moderately impaired and required extensive assistance with transfers.</p>	F 164	<p>- If marked transferred, staff sent it to a different box for further review</p> <p>- If mark deleted, staff read email and removed it from their mailbox</p> <p>- If left blank – see comments written by Nursing Home Administrator</p> <p>3) Additional education was provided through in-servicing completed by the Staff Development Coordinator with all staff to train and/or re-train on following issue: Personal Privacy.</p> <ul style="list-style-type: none"> - The outline for this training (Attachment # 16) is included - The sign-in logs for verification of training (Attachment # 17) are included - All in services were completed by 5/19/11. <p>4) A post test was administered by the Staff Development Coordinator to all LTC staff to ensure the staff understood the provision of privacy. Results were satisfactory compliance by all staff with staff passing the post test as of 6/3/11.</p> <p><u>Criteria # 4</u> - Monitor performance to ensure solutions are sustained:</p> <p>1) The DON will complete routine rounds weekly during times when it is evident that staff is providing in room care with residents to check for all privacy issues.</p> <ul style="list-style-type: none"> - These weekly rounds will be completed as indicated times 6 months and then will be re-evaluated by the DON for continued need. - Any identified issues will be corrected immediately with written documentation regarding specific staff as needed. 	

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
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F 164	Continued From page 12 An observation, on 04/20/11 at 5:10 PM, revealed Resident #6 was sitting on the bedside commode in the middle of his/her room. The privacy curtain was not utilized and the resident was in direct view of the door. The Director of Nursing (DON) entered the room and was able to visualize the resident. The DON did not knock on the resident's door before she entered the room. An interview with the DON, on 04/22/11 at 3:20 PM, revealed she expected staff to pull the privacy curtain when a resident was on the bedside commode. She revealed she should knock on the door before entering a resident's room.	F 164	2) A report of this review will be provided by the DON to the staff monthly and to the QA committee quarterly. - The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO. Criteria # 5 - Date of completion of all corrective action to correct this deficiency and become compliant – 6/4/11	6/4/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: / Based on observation, interviews, record review and review of facility policy and procedures, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse for one resident (#4), in the selected sample of ten (10) residents, related to the failure to investigate a bruise of unknown origin. The findings include:	F 226	<u>F226 SS=D</u> Criteria # 1 - How will corrective action be accomplished for: 1) Resident # 4 - On 4/22/11 an incident investigation was completed by the DON for the identified areas (bruise of unknown origin) - The physician for Resident # 4 was notified of the bruised and scabbed areas via phone call by the Clinical Charge RN (Attachment # 4) - The comprehensive care plan for "At Risk for Impaired Skin Integrity" was updated by the Wound Nurse on 4/22/11 (Attachment # 5 – the updated areas are: Care Plan in place for impaired skin integrity related to #1 scab to top of second toe on left foot, #2 bruise to left heel/ankle area, with interventions to leave open to air, and monitor every shift.	

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F 226	<p>Continued From page 13</p> <p>A review of the policy and procedure "Incident/Accident Reporting", revised 06/07, revealed all staff should complete a full report on injuries discovered of unknown or known origin.</p> <p>A review of the policy and procedure "Abuse/Mistreatment/Neglect of Residents," revised 10/09, revealed through review of all incidents, the facility would be able to identify occurrences, patterns, and trends that may constitute abuse. An incident report would be completed on all occurrences for further review. Each incident would be documented in the "Incident Log" by date and time, to track patterns and trends. If any pattern or trend was identified, further investigation would be initiated.</p> <p>An observation of a skin assessment, on 04/21/11 at 1:30 PM, revealed Resident #4 had a "nickle-sized" bruise on the outer left ankle which appeared dark purple in color, with generalized bruising above the nickle-sized area and was light purple in color.</p> <p>A record review revealed Resident #4 was admitted to the facility on 02/02/09 with diagnoses to include History of Deep Vein Thrombosis and Peripheral Neuropathy. The quarterly Minimum Data Set (MDS), dated 03/06/11, revealed the resident to be cognitively intact and required total assistance with bed mobility.</p> <p>A review of the "Skin Assessment", dated 03/01/11, 03/08/11, 03/15/11, 03/22/11, 03/29/11 04/05/11, 04/12/11, and 04/19/11, revealed no documentation related to the bruising on the resident's left outer ankle.</p>	F 226	<p>Monitor area/site for edema, dressing, redness every shift. C.N.A. to monitor skin daily and notify Charge Nurse of any new areas.)</p> <p>- The TAR was updated by the Wound Nurse on 4/22/11 to include treatment plan for the brown scabbed area (Attachment # 6 – the updated areas are: Monitor scab on second toe left foot and bruise to left ankle and heel every shift.)</p> <p><u>Criteria # 2</u> - How will facility identify other residents:</p> <p>1) By 5/13/11 all residents were assessed for skin issues (including bruising or any areas of unknown origin) by the DON and the Wound Nurse. A summary of this total assessment was completed. (Attachment # 7)</p> <p><u>Criteria # 3</u> - Measures put in place to assure deficient practice will not recur:</p> <p>1) Policy on "Incident/Accident Reporting" was reviewed and updated by the Nursing Home Administrator on 5/12/11 to include a complete investigation of all injuries discovered of unknown origin. (Attachment # 18 – see circled sections marked 'changed')</p> <p>2) Effective 5/1/11, DON will review all incident reports documenting any skin issues to determine need for further review regarding specific issues of unknown origin.</p> <p>3) In servicing was completed with all staff by the Staff Development Coordinator to train and update on "Incident/Accident Reporting" policy.</p> <p>- Outline for training (Attachment # 19) and sign-in log sheets (Attachment # 20) for verification of training included.</p>		

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
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F 226	Continued From page 14 An interview with Licensed Practical Nurse (LPN) #6, on 04/21/11 at 1:30 PM, revealed she did not know anything about the bruising to the resident's left ankle. She revealed the bruising should be documented with an incident report completed. A review of the resident's record revealed there was no documentation of the bruising that was identified by LPN #6 on 04/21/11. An interview with LPN #6, on 04/22/11 at 11:20 AM, revealed she did not document the skin assessment performed on 04/21/11, because she had just assessed the resident's skin on 04/19/11. She revealed she informed Registered Nurse (RN) #1 about the resident's bruising on the outer ankle. LPN #6 revealed she did not complete an incident report and did not call the physician. An interview with RN #1, on 04/22/11 at 11:40 AM, revealed she had not received any report of bruising related to Resident #4. She revealed it would be the responsibility of the nurse taking care of the resident to document the information and notify the physician. An interview with the Director of Nursing (DON), on 04/22/11 at 2:40 PM, revealed the bruising should have been measured and documented on an incident report to determine the cause of the bruise. She expected the nurse to notify the physician.	F 226	- In services were completed by 5/19/11. <u>Criteria # 4</u> - Monitor put in place to assure solutions are sustained: 1) Worksheet has been developed by the DON to monitor all incidents related to investigations for skin issues (Attachment # 13) - This will be completed by the DON on-going. 2) Current monitoring of skin issues will continue as previously in the QA process (by the DON) and will include a section to assure notification of physician regarding changes to any skin area. 3) Monitoring will be completed and reported by the DON monthly to all LTC staff and quarterly to the QA committee. 4) The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO. <u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11	5/20/11
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F280 SS=D <u>Criteria # 1</u> - How will corrective action be accomplished for: 1) Resident # 4	

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F 280	<p>Continued From page 15</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and rview of facility policy and procedure, it was determined the facility failed to develop a comprehensive plan of care to describe services that were to be furnished to maintain highest practicable physical well being for two residents (#1 and #4), in the selected sample of ten (10) residents. These residents required the use of a mechanical lift for transfer; however, the care plan failed to reflect his/her specific needs.</p> <p>The findings include:</p> <p>A review of the policy and procedure "Interdisciplinary Care Planning Process", revised 06/10, revealed care would be planned to</p>	F 280	<p>- On 4/25/11 the mechanical lift device used for this resident was evaluated by the DON for specific safety and further recommendations for use. - This was recorded and updated by the DON on the care plan for Impaired Mobility (Attachment # 21)</p> <p>2) Resident # 1 - On 4/25/11 the mechanical lift device used for this resident was evaluated by the DON for specific safety and further recommendations for use. - This was recorded and updated by the DON on the care plan for Impaired Mobility (Attachment # 22)</p> <p><u>Criteria # 2</u> - How will facility identify other residents:</p> <p>1) On 4/25/11 the DON completed a 100% audit of all residents using mechanical lifts for transfer and also included a 100% audit of the care plans for those identified residents. See summary of audit (Attachment # 23)</p> <p><u>Criteria # 3</u> - Measures put in place to assure deficient practice will not recur: 1) Care plan for Impaired Mobility was revised by DON on 4/25/11 to include specific devices and directions recommended for safe use with each resident during transfers (Attachment # 24 - sample)</p> <p>2) The nursing assessment for "Bedrail, Fall and Device Assessment" was revised by DON on 5/16/11 to include an assessment for safe use of transfer devices.</p>		

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
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F 280	<p>Continued From page 16</p> <p>respond to each resident's unique needs with effective, efficient, and individualized care.</p> <p>1. A record review revealed Resident #4 was admitted to the facility on 02/02/09 with diagnoses to include Osteoporosis, Osteoarthritis and Peripheral Neuropathy.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/06/11, revealed the resident was identified to be cognitively intact and required extensive assistance with transfers.</p> <p>A review of the care plan "Risk for Impaired Skin Integrity", dated 12/07/10, revealed a mechanical lift should be used for transfers. The type of mechanical lift was not specified.</p> <p>There was no documentation on the resident's comprehensive care plans which indicated the specific mechanical lift to use with Resident #4.</p> <p>2. A record review revealed Resident #1 was admitted to the facility on 12/09/10 with diagnoses to include Cerebrovascular Accident, General Global Debility and Inability to Ambulate.</p> <p>A review of the quarterly MDS, dated 02/28/11, revealed the resident to be severely cognitively impaired and extensive assistance with transfers. Range of Motion (ROM) was impaired on one side of the resident's lower extremities.</p> <p>A review of the care plan "Risk for Impaired Skin Integrity", dated 02/11/11, revealed a mechanical lift should be used for transfers. The type of mechanical lift was not specified.</p>	F 280	<p>- This assessment is completed by the Charge Nurse on admission, quarterly and whenever any significant event occurs.</p> <p>- A sample of this assessment is included (Attachment # 25)</p> <p>3) In servicing was completed by the Staff Development Coordinator with all staff to train and update on following issue: Mobility AID/ Device and Care planning.</p> <p>- The outline for this training (Attachment # 26) and sign-in logs (Attachment # 27) for the verification of staff training are attached.</p> <p>- In services were completed by 5/19/11.</p> <p><u>Criteria # 4</u> - Monitor put in place to assure that solutions are sustained:</p> <p>1) Initial care plan will be reviewed by the Multidisciplinary Care Team at the time of the weekly care plan meeting.</p> <p>- Multidisciplinary Care Team Members are: MDS Coordinator, Nursing Home Administrator, DON, Clinical Nursing Coordinator, Wound Nurse, Restorative Nurse Aid, Social Services Worker, Activities Director, Registered Dietitian, PT/OT/ST Representative</p> <p>2) 5 reviews at random will be completed monthly and on-going by the DON on assessment and care plan documentation to assure that safe guidelines are followed for transfers and transfer devices.</p> <p>3) Report will be provided by the DON monthly to the staff and quarterly to the QA committee.</p>	

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F 280	Continued From page 17 There was no documentation on the resident's comprehensive care plans which indicated the specific mechanical lift to use with Resident #1. An interview with Certified Nurse Aide (CNA) #2, on 04/22/11 at 9:15 AM, revealed the type of mechanical lift used for a resident depended on his/her condition. She revealed Resident #4 was transferred with the hoyer (Golvó) lift, because the resident could not bear weight. CNA #2 further revealed the licensed nurse indicated the specific lift on the care plan, but sometimes a resident's family requested a specific lift to be used. An interview with CNA #1, on 04/22/11 at 9:40 AM, revealed she determined which lift to use for a resident based on their condition. She revealed a sit-to-stand (Sabina) lift was used for residents that were able to stand, but needed extra support. The hoyer lift was used for residents unable to walk or bear weight. She revealed the specific lift should be indicated on the resident's care plan. An interview with the Director of Nursing (DON), on 04/22/11 at 3:20 PM, revealed she expected the resident's care plan to reflect a specific mechanical lift, based on an assessment by the licensed staff.	F 280	- The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO. <u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11	5/20/11	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 SS=G <u>Criteria # 1</u> - How will corrective action be accomplished for: 1) Resident # 2 - On 4/25/11, the DON provided the physician for Resident # 2 a complete summary of all skin issues currently identified.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2011
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
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F 309	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and review of facility policy and procedure, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practical physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care for two residents (#2 & #4), in the selected sample of ten (10) residents. The facility failed to ensure staff assessed the progression of a skin tear, which occurred on 10/24/10, to an unstageable wound on 12/20/10. The skin tear was located on the posterior side of Resident #2's left lower leg and deteriorated to an unstageable wound by 12/20/10. On 12/20/10, the wound measured 12.7 cm x 2.0 cm and the depth of the wound was unable to be determined, due to the yellow slough. Additionally, Resident #4 had a brown area on the second toe of the left foot, which measured 0.5 centimeters (cm) x 0.3 cm, and a nickle-sized dark purple discoloration with surrounding light purple discoloration, which was not discovered until observation of a skin assessment on 04/21/11. The nurse had completed a skin assessment on 04/19/11.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure for "Pressure Ulcer Assessment, Prevention and Treatment," dated 10/10, revealed a weekly head to toe physical assessment of the resident's skin was to be completed by licensed personnel, with</p>	F 309	<ul style="list-style-type: none"> - On 4/25/11, the Wound Nurse reviewed the current treatment plan to assure all areas were included and updated the care plan. - Attachments # 1, 2 & 3 – (Note changes on Attachment 3 as follows: Clean with Normal Saline. Apply Normal Saline moist to dry dressing. Apply ABD, wrap with Kerlix, change every shift.) 2) Resident # 4 - On 4/22/11 an incident investigation was completed by the DON for the identified areas (brown scabbed area and the bruised area) - The physician for Resident # 4 was notified of the bruised and scabbed areas via phone call by the Clinical Charge RN (Attachment # 4) - The comprehensive care plan for "At Risk for Impaired Skin Integrity" was updated by the Wound Nurse for Resident # 4 on 4/22/11 (Attachment # 5 – Care Plan in place for impaired skin integrity related to #1 scab to top of second toe on left foot, #2 bruise to left heel/ankle area, with interventions to leave open to air, and monitor every shift. Monitor area/site for edema, dressing, redness every shift. C.N.A. to monitor skin daily and notify Charge Nurse of any new areas.) - The TAR was updated by the Wound Nurse on 4/22/11 to include treatment plan for the brown scabbed area (Attachment # 6 – the updated areas are: Monitor scab on second toe left foot and bruise to left ankle and heel every shift.) 		

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F 309	<p>Continued From page 19 skin impairment referred to the Skin Team.</p> <p>A review of the facility's policy and procedure for "Skin Impairment," dated 02/01/11, revealed basic treatment for skin tears was to assess the skin tear daily for healing, signs and symptoms of infection, and excessive drainage. The policy did not address a defined time frame for notifying the physician about deterioration of the wound status or the need for an alternate treatment.</p> <p>1. Resident #2's clinical record included Pressure Ulcers (coccyx, both hips, right upper back and left lower leg), Osteoporosis, Cardiopulmonary Disease (COPD), Dementia and History of Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>The quarterly Minimum Data Set (MDS), dated 02/20/11, was reviewed and revealed the facility assessed the resident as being severely impaired related to cognition, incontinent of bowel and having an indwelling urinary catheter. The facility noted the resident was totally dependent for mobility and activities of daily living as well as being at risk to develop pressure ulcers.</p> <p>The comprehensive care plan, revised 02/21/11, for "Risk for Impaired Skin Integrity," was reviewed and revealed interventions related to the resident's "High Risk" to develop a pressure ulcer included to perform a head to toe skin assessment weekly, be alert to changes in skin condition daily, use a lift sheet for repositioning, manage friction and shear daily by using a lift sheet, floating heels, keeping the head of the bed elevated no more than 30 degrees, use mechanical lift and an alternating air mattress on</p>	F 309	<p><u>Criteria # 2 - How will facility identify other residents:</u></p> <p>1) By 5/13/11 all residents were assessed for skin issues by the DON and the Wound Nurse. A summary of this total assessment was completed. (Attachment # 7) Physicians were notified if indicated; however, there were no bruises of unknown origin, no unknown pressure areas or new skin tears found.</p> <p>2) By 5/13/11 all resident care plans were updated by DON and Wound Nurse to include time frame for notification of physician regarding changes in skin issues. (Attachment # 8 – sample of the care plan with the circled area indicating the update)</p> <p><u>Criteria # 3 - Measures put in place to assure deficient practice will not recur:</u></p> <p>1) Policy on "Skin Impairment" was reviewed and updated by the MDS Coordinator on 5/12/11 to include the time frame for notification to the physician related to deterioration of the wound status or the need for alternating treatment. (Attachment # 9 – See circled sections marked 'added')</p> <p>2) Policy on "Notification to Physician" was reviewed and updated by the DON on 5/12/11 to include a time frame for notification of any issue related to changes with the resident. (Attachment # 10 – see circled section marked 'added')</p>		

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F 309	<p>Continued From page 20</p> <p>the bed. The care plan did not address physician notification.</p> <p>A review of a physician's fax form, dated 10/24/10 at 12:00 PM, revealed notification of two minor skin tears, facility's current actions included: areas cleansed with normal saline, Vaseline Petroleum applied, covered with 2 x 2 gauze and wrapped with Kerlix. Change daily and as needed (prn). The fax was sent by Licensed Practical Nurse (LPN) #4.</p> <p>The physician's order, dated 10/24/10 at 4:00 PM, were reviewed and revealed an order to clean the skin tear, located on the resident's back side of the left lower leg with normal saline, apply Vaseline and cover with 2 x 2 gauze and wrap with Kerlix gauze daily and prn.</p> <p>The "Long Term Care Wound Observation" documentation, dated 10/24/10 at 5:40 PM, was reviewed and revealed that Registered Nurse (RN) #5 noted a skin tear on the posterior left lower leg, with a small amount of serosanguinous drainage and redness in the center. However, no measurement was noted.</p> <p>Nurse's note, dated 10/24/10 at 7:13 PM, were reviewed and revealed LPN #4 had documented two skin tears on the resident's left lower leg were reported by a nurse aide during morning care. The note indicated that one, skin tear, was on the left posterior lower extremity and the other one was on the inner right side. The nurse noted the areas were cleansed with normal saline, Vaseline applied, covered with 2 x 2 gauze and wrapped with Kerlix. The nurse noted family was notified and a fax form was completed.</p>	F 309	<p>3) Comprehensive care plan for "At Risk for Impaired Skin Integrity" was modified by the MDS Coordinator on 4/25/11 to include information related to physician notification (Attachment # 8) Intervention was added to "notify physician immediately of any decline in skin impairment." (See circled section - marked 'added')</p> <p>4) In servicing was completed with all staff by the Staff Development Coordinator to train and update on following issues: Skin Assessment, Monitoring, Notification and Care Planning. The outline for this training (Attachment # 11) and the sign-in logs (Attachments # 12) for verification of training are included.</p> <p>- In services were completed by 5/19/11.</p> <p><u>Criteria # 4 - Monitor performances to ensure solutions are sustained:</u></p> <p>1) On 5/1/11 the worksheet used previously by the DON was expanded by the DON to monitor all incidents related to investigations for skin issues (Attachment # 13)</p> <p>- This will be completed by the DON / concurrently with each skin incident and a summary will be provided monthly by the DON in a report to the staff at the scheduled monthly staff meeting.</p> <p>- This is an expanded review of skin issues that has been completed by the DON previously and it will be on-going.</p> <p>2) Current monitoring of skin issues will continue as previously in the QA process (by the DON) and will include a section to assure</p>		

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F 309	Continued From page 21 A review of the Treatment Administration Record (TAR), dated October 2010, revealed daily treatment was provided from 10/24/10 through 10/31/10. Review revealed that on 10/28/10 at 11:45 AM, RN #2 documented an observation of the skin tear and noted blood-tinged drainage with a small amount of green drainage. However, there was no documented evidence the residents's physician was notified. Review revealed that on 11/04/10 at 2:23 PM, Licensed Practical Nurse (LPN) #6 documented an observation of the skin tear and noted blood-tinged drainage. However, there no documented evidence of physician notification. Review revealed that on 11/11/10 at 3:05 PM, LPN #6 documented an observation of the resident's skin tear and noted yellow/green drainage. However, there was no documented evidence the resident's physician was notified. On 11/15/10 at 10:30 AM, LPN #3 (Wound Nurse), documented the following regarding the skin tear: skin tear with minimal green drainage and the skin flap was missing. There was dark pink tissue in the center with pink surrounding edges. The treatment was changed to clean the wound with normal saline, apply Visco paste loosely, cover with Kerlix, secure with paper tape and change every five days and as needed (prn). A notification of the change in treatment was faxed to the attending physician on 11/15/10 by LPN #3. However, review of the TAR, dated November 2010, revealed there was no	F 309	notification of physician regarding changes to any skin area. 3) Monitoring will be completed and reported by the DON monthly to all LTC staff and quarterly to the QA committee. - The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO. <u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11	5/20/11

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F 309	<p>Continued From page 22</p> <p>documented evidence of the change in treatment until 11/25/10. Documentation on the TAR revealed the treatment ordered for every five days and as needed (prn) was completed on 11/25/10 and 11/30/10.</p> <p>Additional review of the TAR, dated December 2010, revealed treatments were completed as ordered (every five days), on 12/05/10, 12/10/10, 12/15/10 and 12/20/10.</p> <p>Review of weekly skin assessments, dated 11/25/10 through 12/16/10, revealed there was no documented evidence related to the skin tear on the resident's posterior left lower leg.</p> <p>A nurse's notes, dated 12/20/10 at 3:24 PM, revealed LPN #3 (Wound Nurse), revealed that "upon dressing change to the left lower leg, the wound showed great decline, and was no longer a skin tear but an unstageable pressure ulcer." She described the tissue in the wound base as consisting of 100% yellow slough against a bony prominence. The nurse measured the wound as 12.7 cm x 2.0 cm and noted she was unable to determine the depth due to the yellow slough. On 12/20/10, no time indicated, an order from the attending physician revealed to consult with the Wound Care physician. The nurse revealed the physician (Wound Care Specialist) was notified for consultation.</p> <p>A review of the Wound Care physician's consultation, dated 12/21/10, described the wound on the posterior left calf as a long, irregular-shaped, deep stage III decubitus ulcer which measured 16 cm in length x 1 cm in width. The physician made a recommendation for a new</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>treatment to be completed twice daily. He revealed due to the resident's advanced age, the likelihood that the lesions would heal was remote.</p> <p>An observation, 04/20/11 at 2:00 PM, revealed wound care was provided and wound measurements were completed by LPN #3, (Wound Nurse). She was accompanied by other members of the Wound Care Team which included the Director Of Nursing (DON), the Clinical Care Coordinator and the Registered Dietician. The wound on the back of the left lower leg measured 10.6 cm long x 0.5 cm wide, with a depth of 0.8 cm. LPN #3, (Wound Nurse) stated the wound started out as a skin tear and progressed to an unstageable wound. She was unable to give an explanation of how or why this occurred.</p> <p>An interview with LPN #3 (Wound Nurse), on 04/21/11 at 9:55 AM, revealed the wound initially presented as a skin tear and treatment was changed but to the skin tear was not healing. LPN #3 stated a new treatment was initiated on 11/15/10 and continued for awhile to see if it worked; however, the wound continued to worsen over time. She revealed she was off from work for two days in December 2010, and by the time she returned, the wound had changed drastically. The LPN stated she did the weekly wound assessments and the unit nurses conduct the weekly skin assessments. She stated if the nurses noticed any changes in wound status, they should notify the physician immediately for a treatment change or contact her if they needed to do so. Continued interview with LPN #3 at 6:30 PM, revealed if it was not documented, then there was no communication with the physician. She</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>indicated when a wound was identified to contain blood-tinged or yellow/green drainage, the physician should be notified. She stated the physician should be notified whenever a wound changes for the worse and was not able to explain why the physician was not notified.</p> <p>An interview with LPN #4, on 04/21/11 at 4:00 PM, revealed she did weekly skin assessments and occasionally did wound care on weekends. She stated if she observed a change in a wound, she notified the Charge Nurse or the Wound Nurse.</p> <p>An interview with LPN #2, on 04/22/11 at 9:15 AM, revealed she did weekly skin assessments and wound care if the Wound Nurse was off. She stated she reviewed the previous weekly assessment in order to be familiar with any area noted. If she noted any changes, she would get another nurse to observe the area and document the change. If this occurred during the week (Monday through Friday), she notified the Wound Nurse. If occurred on the weekend, she notified the Charge Nurse, documented on the shift report and the treatment book. She stated she did not remove any dressings unless they were saturated. They were usually changed prn and she acknowledged that they were intact.</p> <p>An interview with LPN #1, on 04/22/11 at 10:30 AM, revealed she was trained during orientation to do skin assessments and assessed for anything out of the ordinary. If she noted anything, she went to the Wound Nurse. She used the treatment book to verify any new areas and for comparison of old areas and if she noted a significant change in a wound she notified the</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>physician. LPN #1 indicated she changed an existing dressing if there was drainage noted, or it was due to be changed and the Wound Nurse was not there.</p> <p>During an interview with RN #2 (Charge Nurse), on 04/22/11 at 10:00 AM, revealed she conducted admission skin assessments and wound care occasionally. She stated she expected the nurses to notify her to collaborate on skin concerns and any nurse could contact a physician with concerns. She stated nurses conducting skin assessments should remove the dressings to assess wounds, and if the wound was declining, the physician should be notified.</p> <p>Interviews with Certified Nurse Aides (CNAs) #1, #2, #3, #4 and #5, on 04/22/11 at 9:30 AM, revealed they were trained to observe residents for any skin injury or unusual changes and to immediately report to the Unit Nurse or the Charge Nurse. However, they could provide no explanation related to the decline of the skin tear on Resident #2's lower left leg.</p> <p>During an interview with the DON, on 04/22/11 at 3:20 PM, she indicated nurses on the unit did weekly skin assessments and looked at the wounds depending on the treatment. She stated the nurses usually did not take off dressings because the Wound Nurse did wound treatments daily and the Wound Team did weekly rounds on Wednesdays, but if the nurses observed a change in a wound she expected the physician to be notified.</p> <p>During an interview with Resident #2's physician, on 04/21/11 at 2:00 PM, she indicated she usually</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>consulted with a wound surgeon regarding wounds. She stated she was notified about the resident's skin tear on 10/24/10 and about a change in treatment on 11/15/10, but did not recall any other communication with staff, related to the skin tear, until contacted on 12/20/10. The physician indicated she ordered a referral for a consult with the wound surgeon related to the resident's wounds. She stated she expected to be notified if the wound became worse. Further interview, on 04/22/11 at 11:10 AM, revealed if she had been notified of the worsening of the skin tear sooner, she would have taken action and consulted with the wound surgeon sooner and also referred the resident to Physical Therapy for a wound management program. The physician stated the green drainage may have indicated the presence of infection, but this could only be confirmed by a culture.</p> <p>An interview with the Wound Care physician, on 04/22/11 at 11:45 AM, revealed the wound was related to pressure and he did not recognize the wound was related to a deteriorating skin tear.</p> <p>An interview with the Administrator, on 04/22/11 at 2:15 PM, revealed the staff did not follow the facility's process related to monitoring the skin tear and notification of the physician in order to prevent the decline in the wound.</p> <p>2. Review of Resident #4's record revealed an admission date of 02/02/09 with diagnosis which included a History of Deep Vein Thrombosis and Peripheral Neuropathy.</p> <p>Reviews of the annual Minimum Data Set (MDS),</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>dated 12/06/10, and the quarterly MDS, dated 03/06/11, revealed the facility assessed the resident to be cognitively intact and required total assistance with bed mobility.</p> <p>A review of the "Skin Assessments", dated 03/01/11, 03/08/11, 03/15/11, 03/22/11, 03/29/11 04/05/11, 04/12/11, and 04/19/11, revealed no documentation related to the Resident #4's second toe on the left foot or the bruising on the left outer ankle.</p> <p>During an observation of a skin assessment, on 04/21/11 at 1:30 PM, revealed Resident #4 had a brown area on the second toe of the left foot. The area measured 0.5 centimeters (cm) in length x 0.3 cm width. The brown area noted to have been dry, with redness around the perimeter. The resident's outer left ankle was noted to have a "nickle-sized" bruise which appeared dark purple in color, with generalized bruising above the nickle-sized area, which was noted to be light purple in color.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6, on 04/21/11 at 1:30 PM, revealed she completed the resident's skin assessment on 04/19/11, and did not notice the brown area on the second toe of the left foot. LPN #6 was unaware of bruising on the resident's left ankle. She revealed the bruising should have been documented with an investigation report completed. The area on the left second toe was not "open", and should have been documented to monitor the area.</p> <p>Further interview with LPN #6, on 04/22/11 at 11:20 AM, revealed she did not document the</p>	F 309			

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F 309	Continued From page 28 skin assessment performed on 04/21/11, because she had assessed the resident's skin on 04/19/11. She indicated she informed Registered Nurse (RN) #1 about the resident's area on the left second toe and the bruising on the outer ankle. LPN #6 stated, "We do not call the physician unless we find something major. I did not fax the physician because the area was minor." She stated, "The area on the resident's toe looked like a scab, ready to fall off." During an interview with RN #1, on 04/22/11 at 11:40 AM, she stated she had not received any report of skin breakdown or bruising related to Resident #4. The RN indicated was the responsibility of the nurse taking care of the resident to document and notify the physician. Interviews with Certified Nurse Aides (CNAs) #2 and #3, on 04/21/11 at 4:55 PM, revealed all of the CNAs rotated areas and did not always work the same unit. Each of them stated they had not noticed any bruising on the resident's ankle or any areas on the resident's toes until it was pointed out by the surveyor. An interview with the Director of Nursing (DON), on 04/22/11 at 2:40 PM, revealed the area on the resident's left second toe should be measured and documented as a "brown scabbed area that was unstageable." She revealed the bruising should have been measured and documented on an investigation report to determine the cause of the bruise. She expected the nurse to notify the physician of both skin issues.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	F314 SS=D Criteria # 1 - How will corrective action be accomplished for:		

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F 314	<p>Continued From page 29</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure two residents (#4 & #7), in the selected sample of ten (10) residents, who entered the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. Resident #4 had an area on the left second toe, right below the nailbed. The area measured 0.5 centimeters (cm) length by 0.3 cm width, and was brown in color. There was no drainage, but the perimeter around the area was reddened. Resident #7 had an area to the right second toe left lateral aspect. The perimeter area was pinkish-red in color and white in the middle. Resident #7 was admitted to the facility on 03/29/11 with a suspected deep tissue injury to his/her heel.</p> <p>The findings include:</p> <p>1. A record review revealed Resident #7 was admitted to the facility on 03/29/11 with diagnoses to include Sepsis of the Right Knee, Anemia and Rheumatoid Arthritis. A review of the admission</p>	F 314	<p>1) Resident # 7</p> <ul style="list-style-type: none"> - On 4/21/11 an incident investigation was completed by the LPN for the identified area to the resident's right 2nd toe. - The physician was notified by the LPN (Attachment # 28), orders obtained by the LPN(Attachment # 29), treatment initiated on the TAR by the LPN (Attachment #30 – Treatment added 4/21/11 for cotton ball between first and second toes on right foot to reduce pressure. Monitor every shift.) and Care Plan completed by the LPN (Attachment # 31 – Care Plan updated 4/21/11 to place cotton ball between first and second toes of right foot to reduce pressure. Monitor every shift.) <p>2) Resident # 4</p> <ul style="list-style-type: none"> - On 4/22/11 an incident investigation was completed by the DON for the identified areas (brown scabbed area and the bruised area) - The physician for Resident # 4 was notified of the bruised and scabbed areas via phone call by the Clinical Charge RN (Attachment # 4) - The comprehensive care plan for "At Risk for Impaired Skin Integrity" was updated by the Wound Nurse for Resident # 4 on 4/22/11 (Attachment # 5 – the updated areas are: Care Plan in place for impaired skin integrity related to #1 scab to top of second toe on left foot, #2 bruise to left heel/ankle area, with interventions to leave open to air, and monitor every shift. Monitor area/site for edema, dressing, redness every shift. C.N.A. to monitor skin daily and notify Charge Nurse of any new areas.) 	

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F 314	<p>Continued From page 30</p> <p>Minimum Data Set (MDS), dated 04/11/11, revealed a Brief Interview of Mental Status (BIMS) score of "14." Resident #7 was cognitively intact. The resident was identified to be at risk for developing pressure sores with a pressure reduction mattress and pillows implemented.</p> <p>An observation of a skin assessment, on 04/21/11 at 2:19 PM, revealed the resident was lying in bed, awake and alert. The resident was cooperative and voiced he/she did not feel very well. The resident voiced he/she was there for therapy so that he/she could walk and return home. An area was noted to the resident's right second toe after the surveyor asked the staff to look between his/her toes. The area was located on the left lateral aspect of his/her second toe on his/her right foot. The area was pinkish-red in color with white in the middle.</p> <p>A review of skin assessments dated 03/29/11, 04/08/11 and 04/14/11 revealed no identified skin issue on the resident's toe.</p> <p>An interview with Licensed Practical Nurse (LPN) #7, on 04/21/11 at 2:19 PM, revealed the nurse on the unit completed a weekly skin assessment on the residents. The wound nurse completed an assessment weekly on residents with wounds. LPN #7 stated Resident #7 had an area to his/her heel and every shift the staff looked at his/her heels. She revealed she was not aware of the area on the resident's right second toe and he/she had a skin assessment completed a couple days ago. She stated the area looked like pressure from Resident #7's great toe and noted the area to Resident #7's toe was not open.</p>	F 314	<p>- The TAR was updated by the Wound Nurse on 4/22/11 to include treatment plan for the brown scabbed area (Attachment # 6 – the updated areas are: Monitor scab on second toe left foot and bruise to left ankle and heel every shift.)</p> <p><u>Criteria # 2</u> - How will facility identify other residents:</p> <p>1)-By 5/13/11 all residents were assessed for skin issues by the DON and the Wound Nurse. A summary of this total assessment was completed. (Attachment # 7) Physicians were notified if indicated; however, there were no bruises of unknown origin, no unknown pressure areas or new skin tears found.</p> <p>2) By 5/13/11 all resident care plans were updated by DON and Wound Nurse to include time frame for notification of physician regarding changes in skin issues. (Attachment # 8 – sample of the care plan with the circled area indicating the update</p> <p><u>Criteria # 3</u> - Measures put in place to ensure deficient practice will not recur:</p> <p>1) In servicing was completed with all staff by the Staff Development Coordinator to train and update on following issues: Skin Assessment, Monitoring, Notification and Care Planning. The outline for this training (Attachment # 11) and the sign-in logs (Attachments # 12) for verification of training are included.</p> <p>- In services were completed by 5/19/11.</p>	

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F 314	<p>Continued From page 31</p> <p>An interview with LPN #3, on 04/21/11 at 6:35 PM, revealed she was the wound nurse in the facility. She stated if a nurse found a new area, then they were expected to measure the area, document on a weekly wound observation and in the nurse's notes what they found and what they did about it. Additionally, the nurse contacted her regarding what they identified.</p> <p>An interview with the DON, on 04/22/11 at 3:20 PM, revealed the nurse on the unit completed a weekly skin assessment. If a resident had a treatment with a dressing in place, the nurse did not necessarily remove the dressing at the time of the skin assessment. If an aide identified a skin issue, then they reported that to the LPN assigned, Charge Nurse or to the Wound Nurse (LPN #3). The nurse notified the physician and proceeded with the direction of the physician.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 02/02/09 with diagnoses to include Deep Vein Thrombosis, Osteoporosis, Osteoarthritis and Peripheral Neuropathy.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/06/11, revealed Resident #4 to be cognitively intact and required extensive assistance with bed mobility. No pressure sores were indicated on the MDS.</p> <p>A review of the "Skin Assessments", dated 03/01/11, 03/08/11, 03/15/11, 03/22/11, 03/29/11, 04/05/11, 04/12/11, and 04/19/11, revealed no documentation related to the area on the resident's left second toe.</p>	F 314	<p><u>Criteria # 4 - Monitor performance to ensure that solutions are sustained:</u></p> <p>1) Current monitoring of skin issues will continue as previously in the QA process (by the DON) and will include a section to assure notification of physician regarding changes to any skin area.</p> <p>2) Monitoring will be completed and reported by the DON monthly to all LTC staff and quarterly to the QA committee. - The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO</p> <p><u>Criteria # 5 - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11</u></p>	5/20/11

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F 314	<p>Continued From page 32</p> <p>An observation of a skin assessment, on 04/21/11 at 1:30 PM, revealed Resident #4 had an area to the left second toe, right below the nailbed. The area measured 0.5 centimeters (cm) length by 0.3 cm width, and was brown in color. There was no drainage, but the perimeter around the area was reddened.</p> <p>The skin assessment performed by Licensed Practical Nurse (LPN) #6, on 04/21/11 at 1:30 PM, was not documented in the resident's record on 04/22/11.</p> <p>An interview with LPN #6, on 04/21/11 at 1:30 PM, revealed the area on the resident's toe was not a new area. She revealed the area was not "open", so it should just be monitored.</p> <p>Interview with LPN #6, on 04/22/11 at 11:20 AM, revealed she did not chart the skin assessment performed on 04/21/11 because she had just completed a skin assessment for the resident on 04/19/11. She revealed Registered Nurse (RN) #1 was informed about the area on the resident's left second toe, but RN #1 instructed her to leave the area open so it would not become "too moist." She did not notify the physician (by fax or phone) because the area to the resident's left second toe was "minor." She revealed the physician would be notified if the area was "something major."</p> <p>An interview with RN #1, on 04/22/11 at 11:40 AM, revealed she did not receive a report of an "area" found during Resident #4's skin assessment, on 04/21/11. She revealed the nurse that performed the skin assessment would be responsible for documenting skin breakdown, as well as notification of the physician.</p>	F 314			

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F 314	Continued From page 33 An interview with the Director of Nursing (DON), on 04/22/11 at 2:40 PM and 3:20 PM, revealed she observed the resident's left second toe at 2:40 PM. The area should have been measured and documented in the resident's record, and the physician should have been notified. She revealed she would have documented the area as "a brown scabbed area, that was unstageable." She stated "The area looked like an abrasion, like it had rubbed up against something."	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and review of facility policy and procedure, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and received adequate supervision and assistance to prevent accidents for three residents (#1, #4, and #6), in the selected sample of ten (10) residents. Resident #4 was not assessed for the safe use of a mechanical lift, and sustained a fall from a lift that resulted in three fractured ribs. Resident #6 was not assessed for the safe use of a	F 323	F323 SS=D <u>Criteria # 1</u> - How will corrective action be accomplished for: 1) Resident # 4: - Addendum to the "Bedrail/Fall/Device Assessment was completed by the DON on 4/25/11 (Attachment # 32 - circled area handwritten at the end of the assessment) to define safe measures for transferring resident # 4. - The Care Plan was also updated by the DON for Resident # 4 (Attachment # 21) to include safe measures for transfer. 2) Resident # 6: - Addendum to the "Bedrail/Fall/Device Assessment was completed by the DON on 4/25/11 (Attachment # 33 - circled area handwritten at the end of the assessment) to define safe measures for transferring resident # 6.		

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F 323	<p>Continued From page 34</p> <p>mechanical lift, and observation revealed improper use of the lift. The lift was left attached to Resident #6 while unsupervised. The facility did not assess Resident #1 for the safe use of a mechanical lift.</p> <p>The findings include:</p> <p>A review of the policy and procedure "Positioning/Mobility & Pressure Reduction Devices," dated 05/10, revealed appropriate mobility devices should be chosen by matching a device's potential therapeutic benefit with the resident's specific situation. A mobility device assessment should address the resident's mobility, rationale for the device, potential risks and benefits of the device, and an evaluation of the benefit and risk of the device.</p> <p>1. A record review revealed Resident #4 was admitted to the facility on 02/02/09 with diagnoses to include Osteoporosis, Osteoarthritis, Anxiety and Peripheral Neuropathy.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/06/11, revealed the resident was identified to be cognitively intact and required extensive assistance with transfers.</p> <p>A review of the "Long Term Care Restorative Assessment", dated 03/07/11, revealed the resident transferred with the Hoyer (Golvo) lift. A review of the "Bedrail/Fall/Device Assessment", dated 03/19/11, revealed a mechanical lift was used for the resident during transfer. There was no documentation in the resident's record which indicated the Hoyer lift was determined to be a safe device for Resident #4.</p>	F 323	<p>- The Care Plan was also updated by the DON for Resident # 6 (Attachment # 34) to include safe measures for transfer.</p> <p>3) Resident # 1:</p> <p>- Addendum to the "Bedrail/Fall/Device Assessment was completed by the DON on 4/25/11 (Attachment # 35 – circled area hand written at the end of the assessment) to define safe measures for transferring resident # 1.</p> <p>- The Care Plan was also updated by the DON for Resident #1 (Attachment # 22) to include safe measures for transfer.</p> <p><u>Criteria # 2</u> - How will facility identify other residents:</p> <p>1) On 4/25/11 the DON completed a 100% audit of all residents using mechanical lifts for transfer and also included a 100% audit of the care plans for those identified residents. See summary of audit (Attachment # 23)</p> <p><u>Criteria # 3</u> - Measures put in place to ensure deficient practice will not recur:</p> <p>1) Care plan for Impaired Mobility was revised by the DON on 4/25/11 to include specific devices and directions recommended for safe use with each resident during transfers (Attachment # 24)</p> <p>2) The nursing assessment for "Bedrail, Fall and Device Assessment" was revised by the DON on 5/16/11 to include an assessment for safe use of transfer devices.</p>		

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F 323	<p>Continued From page 35</p> <p>A review of the "Nursing Notes", dated 04/13/11 at 9:15 AM, revealed the resident was found lying in the floor on the Hoyer lift sling. Resident #4 sustained a skin tear on the lower left leg, and complained of pain to the ribs as a result of the fall.</p> <p>A review of the "X-ray report", dated 04/13/11, revealed the resident sustained nondisplaced fractures of the left 5th, 6th, and 7th ribs.</p> <p>An interview with Resident #4, on 04/22/11 at 2:00 PM, revealed the resident was scared after the fall from the Hoyer lift. The resident stated "I hit hard, broke three ribs." Resident #4 revealed the pain was not any better since the fall. The resident was not sure when the staff resumed transfer using the lift, but stated "I did not get back in the lift the day I fell."</p> <p>An interview with Certified Nurse Aide (CNA) #4, on 04/22/11 at 3:30 PM, revealed she was the aide taking care of Resident #4 on 04/13/11. She attempted to transfer the resident from the bed to the geri-chair, with the Hoyer lift. She attempted to lower the resident into the chair when the Hoyer lift "flipped." She revealed she did not have an inservice over the use of the Hoyer lift until after the incident with Resident #4. She was "checked off" as competent to use the mechanical lift by another CNA.</p> <p>A review of the "Nurse Aide Skills Checklist", dated 03/16/11, revealed CNA #4 was "checked off" for the use of the mechanical lift by her preceptor, another CNA. The facility could not provide documentation of an inservice over the</p>	F 323	<p>- This assessment is completed by the Charge Nurse on admission, quarterly and whenever any significant event occurs.</p> <p>- A sample of this assessment is included (Attachment # 25)</p> <p>3) In servicing was completed by the Staff Development Coordinator with all staff to train and update on following issue: Mobility AID/ Device and Care planning.</p> <p>- The outline for this training (Attachment # 26) and sign-in logs (Attachment # 27) for verification of staff training are attached.</p> <p>- In services were completed by 5/19/11.</p> <p><u>Criteria # 4 - Monitor performance to ensure that solutions are sustained:</u></p> <p>1) Initial care plan will be reviewed by the Multidisciplinary Care Team at the time of the weekly care plan meeting.</p> <p>- Multidisciplinary Care Team Members are: MDS Coordinator, Nursing Home Administrator, DON, Clinical Nursing Coordinator, Wound Nurse, Restorative Nurse Aid, Social Services Worker, Activities Director, Registered Dietitian, PT/OT/ST Representative</p> <p>2) 5 reviews at random will be completed monthly and on-going by the DON on assessment and care plan documentation to assure that safe guidelines are followed for transfers and transfer devices.</p> <p>3) Report will be provided by the DON monthly to the staff and quarterly to the QA committee.</p>	

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F 323	<p>Continued From page 36 mechanical lift prior to 04/13/11.</p> <p>An interview with CNA #2, on 04/22/11 at 9:15 AM, revealed she was in the room when Resident #4 fell from the Hoyer lift. She revealed CNA #4 was controlling the lift, when the base of the lift started to come up off the floor. The lift was lowered to the side by CNA #4, landing on CNA #4's shoulder. The resident fell beside the geri-chair. The resident complained of "side" pain, and sustained a small skin tear, but "The resident was more scared than anything."</p> <p>An interview with the Administrator, on 04/22/11 at 4:10 PM, revealed the facility determined CNA #4 should have moved the lift closer to the chair during the transfer on 04/13/11.</p> <p>An interview with the Director of Nursing (DON), on 04/22/11 at 3:20 PM, revealed she expected the Staff Development Coordinator (RN #3) to ensure the CNAs were competent before they were out of orientation.</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 03/25/11 with diagnoses to include Debility, Osteoporosis, Generalized Weakness and Osteoarthritis with Chronic Pain.</p> <p>A review of the admission MDS, dated 04/04/11, revealed the resident was identified to be moderately impaired and required extensive assistance with transfers. Range of Motion (ROM) was impaired on both sides of lower extremities.</p> <p>A review of the "Bedrail/Fall/Device Assessment",</p>	F 323	<p>- The QA Committee consists of the following: Medical Director, Director of Nursing, Nursing Home Administrator, Social Service Worker, Infection Control Nurse and representatives from Muhlenberg Community Hospital – the CEO and CNO.</p> <p><u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant - 5/20/11</p>	5/20/11	

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 323	<p>Continued From page 37</p> <p>dated 03/25/11, 04/13/11, and 04/19/11, revealed no documentation related to the sit-to-stand lift. A review of the "Long Term Care Restorative Assessment", dated 04/21/11, revealed the resident was lifted mechanically by use of the sit-to-stand lift. There was no evidence the facility assessed Resident #6 for the safe use of the mechanical lift.</p> <p>An observation, on 04/20/11 at 10:15 AM, revealed Resident #6 was transferred, by use of the sit-to-stand (Sabina) lift, from the wheelchair to the bedside commode. CNA #6 and CNA #7 performed the transfer, without the use of the "calf" strap.</p> <p>An observation, on 04/20/11 at 5:10 PM, revealed Resident #6 was on the bedside commode in his/her room, with the door closed. There was no staff in the room during the observation. The lift "vest" was secured around the resident, with the base of the lift under the bedside commode.</p> <p>An interview with CNA #6, on 04/20/11 at 5:15 PM, revealed she used the "calf" strap when a resident had trouble standing with the lift, but stated "I did not think it had to be used all the time."</p> <p>An interview with CNA #7, on 04/20/11 at 5:20 PM, revealed she was taught to use the "calf" strap when using the Sabina lift. She stated "We use the strap to support the resident's legs." She revealed she should have used the "calf" strap with Resident #6.</p> <p>An interview with the DON, on 04/20/11 at 5:30 PM and 04/22/11 at 3:20 PM, revealed the "calf"</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 323	<p>Continued From page 38</p> <p>strap should always be secured. She expected all straps to be secured, even if a resident was being transferred a short distance. She revealed a resident should not be left unattended with the Sabina lift attached to them.</p> <p>3. A record review revealed Resident #1 was admitted to the facility on 12/09/10 with diagnoses to include Cerebrovascular Accident, General Global Debility, and Inability to Ambulate.</p> <p>A review of the quarterly MDS, dated 02/28/11, revealed the resident was identified to be severely cognitively impaired and required extensive assistance with transfers. ROM was impaired on one side of the lower extremities.</p> <p>A review of the "Bedrail/Fall/Device Assessment", dated 04/21/11, revealed Resident #1 was transferred with a mechanical lift. The "Long Term Care Restorative Assessment", dated 04/21/11, revealed the Hoyer lift was used for the resident for transfers to the geri-chair. There was no documentation related to the safe use of the lift for the resident.</p> <p>An interview with Registered Nurse (RN) #3, on 04/21/11 at 11:10 AM, revealed she documented the restorative note which specified the use of the mechanical lift for residents, but did not assess the residents for the safe use of the lift.</p> <p>An interview with RN #4, on 04/22/11 at 12:00 PM, revealed he worked as a Charge Nurse, but did not assess the residents on admission for the safe use of the lift.</p> <p>An interview with the Physical Therapy Assistant,</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346	
(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 323	Continued From page 39 on 04/22/11 at 2:10 PM, revealed the physical therapist does evaluations on the residents, but did not assess for the safe use of the mechanical lifts. She stated "We do not use the Hoyer lifts at all." An interview with the DON, on 04/21/11 at 11:00 AM, revealed there were no assessments of residents related to the safe use of the mechanical lift.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policy and procedure, it was determined the facility failed to store, prepare and serve food under sanitary conditions. Observations revealed staff in the kitchen without hair completely restrained in a hair net, food items not dated in the freezer, food items temperatures were not checked prior to service, improper sanitation of the thermometer and food served without sanitizing their hands after leaving the tray line area.	F 371	F371 SS=E <u>Criteria # 1</u> - How will corrective action be accomplished for: 1) Failure to store under sanitary conditions and identify - The two bags of peas, two bags of shrimp, two bags of mozzarella cheese sticks and bag of tilapia were rewrapped, labeled and dated by the Dietary Director on 4/20/11. - The bag of opened fish was discarded by the Dietary Director on 4/20/11. 2) Staff assigned to tray line without hair completely covered - The two identified staff received verbal counseling along with review of the department policy guidelines regarding "Proper Way to Wear a Hair Net" by the Dietary Director on 4/20/11 - These guidelines were signed by the two identified staff and are attached (Attachments # 36 & # 37)	

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 371	<p>Continued From page 40</p> <p>The findings include:</p> <p>A review of the policy entitled "Handwashing & Personal Cleanliness Policy," dated 8/09, revealed the Sodexo policy requires that all employees wash hands after using restroom facilities and again in production or service areas before returning to work, after handling raw meat, poultry, seafood and produce, before starting to work and when returning from breaks, before working with ready-to-eat food, between handling different types of food, after touching hair, face, nose or other parts of the body, after handling chemicals, after handling dirty equipment, after handling trash and contaminated objects.</p> <p>A review of the policy entitled "HACCP/Food Safety Program," dated 8/09, revealed employees wear approved hair restraints and clean uniforms, aprons and shoes. Hair restraints must cover hair sufficiently to prevent hair from falling onto food or food equipment and to minimize hand contact with hair. Disposable glove must be used when handling read to eat foods. Gloves must be changed before starting another job and when they are torn, dirty or contaminated. Hands must be washed before putting on gloves. All food handlers have access to and use cleaned, sanitized and calibrated thermometers. Thermometers must be sanitized between each food item.</p> <p>1. Observation of the walk-in freezer, on 04/20/11 at 10:40 AM, revealed two bags of peas, two bags of shrimp, two bags of mozzarella cheese sticks, a bag of tilapia, and one ziplock bag of fish opened, not labeled and not dated. An interview with the Dietary Manager (DM), at</p>	F 371	<p>3) Cook not sanitizing thermometer between food checks of different food I</p> <ul style="list-style-type: none"> - Identified staff received verbal counseling along with a review of the department policy guidelines regarding "Thermometer Calibration and Sanitation" by the Dietary Director on 4/20/11 - These guidelines were signed by the identified staff and attached (Attachment # 38) <p>4) Cook tying apron with gloved hands and then wiping gloved hands on pants leg</p> <ul style="list-style-type: none"> - Identified staff received verbal counseling and review of department policy guidelines regarding "Handwashing and Personal Cleanliness" by the Dietary Director on 4/20/11 - These guidelines were signed by the identified staff and attached (Attachment # 39) <p>5) Cook placing microwaved items in bowl or on plate without checking temperatures</p> <ul style="list-style-type: none"> - Identified staff received verbal counseling and review of department policy regarding "Thermometer Calibration and Sanitation" by the Dietary Director on 4/21/11 - These guidelines were signed by the identified staff and attached (Attachment # 38) <p><u>Criteria # 2 - How will facility identify other areas of concern in the dietary section:</u></p> <p>1) Food safety labeling/dating, proper wearing of hair net, thermometer calibration and sanitation and handwashing/personal</p>		

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346	
(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 371	<p>Continued From page 41</p> <p>the time of the observation, revealed all of those items should be labeled and dated when opened.</p> <p>2. An observation, during the tray line service for the evening meal, on 04/20/11 at 4:25 PM, revealed two staff members on the tray line placed plates of food and plate covers without their hair completely restrained with a hair net.</p> <p>3. An observation, on 04/20/11 at 4:25 PM, revealed the cook was sticking her thermometer in the mashed potatoes, gravy, beef broth, pureed chicken, pureed peas, broccoli, red potatoes, green beans, spaghetti sauce, and northern beans without proper sanitation. The cook stuck the thermometer in the food items and either wiped the thermometer on a hand towel she used to wipe her hands with or not sanitize the thermometer.</p> <p>4. At 4:47 PM, the cook was observed to tie her apron with gloved hands during meal service and then wiped her hands down the sides of her pants without removing her gloves, washing her hands and donning a new pair of gloves.</p> <p>5. At 5:10 PM, the cook was observed microwaving a can of tomato soup, corn, and cornbread dressing, then place food items in a bowl or on a plate without checking the temperature.</p> <p>An interview with the Cold Preparations Aide/Runner, on 04/21/11 at 10:00 AM, revealed she had been working in the facility 8 or 9 weeks. She stated she was informed to use a hair net and keep all hair underneath the net.</p>	F 371	<p>cleanliness are infection control issues that have the potential to place all residents at risk.</p> <p><u>Criteria # 3</u> - Measure put in place to ensure deficient practice will not recur:</p> <p>1) A mandatory in service was provided by the Dietary Director for all dietary staff on 5/17/11. - Outline of this review is included (Attachment # 40) - A staff sign-in log is also attached for verification of staff training (Attachment # 41)</p> <p><u>Criteria # 4</u> - Monitor performance to ensure that solutions are sustained:</p> <p>1) The Dietary Director will monitor proper labeling and dating of all food weekly and provide results monthly to the staff and the Nursing Home Administrator.</p> <p>2) The Dietary Director will monitor staff as they prepare and serve food under sanitary conditions on a random basis each shift and weekly and provide a monthly report to the staff and the Nursing Home Administrator.</p> <p><u>Criteria # 5</u> - Date of completion of all corrective action to correct this deficiency and become compliant – 5/18/11</p>	5/18/11

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 371	<p>Continued From page 42</p> <p>An interview with the Cook, on 04/21/11 at 10:30 AM, revealed she knew her hair had to be completely covered when preparing food. She stated she could not have any dangling earrings and rings with a set in. She stated she did not realize the front part of her hair was not restrained with the hair net. "We are not suppose to have any hair hanging out and that information was in our hand book".</p> <p>An interview with the evening Cook, on 04/22/11 at 11:15 AM, revealed she had gotten nervous when she was checking the temperature of the food on the steam table. She stated she used alcohol pads to clean the thermometer between foods items and had messed up that day by wiping the thermometer on the hand towel. She stated when microwaving food, she did not check the temperature before serving. "If I see steam coming from the food, then it is hot enough". The evening cook revealed she knew the food had to be hot when served but could not determine if temperature appropriate unless checked with the thermometer. Additionally, she stated she touch the dressing with her gloved hands after handling different serving ladles. She stated she knew she should have washed her hands and changed her gloves, especially when she had left the serving area.</p> <p>An interview with the Dietary Manager and a Dietary Aide, on 04/21/11 at 9:15 AM, revealed the staff were expected to have their hair nets on with their hair completely restrained. The cooks have numerous thermometer to check the food temperatures and should use the proper procedure of sanitizing the thermometer between each food item. The staff know to change gloves</p>	F 371			

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STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2011
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 371	Continued From page 43 and wash their hands between different task in the kitchen. Also, if they were tying aprons and rubbing their pants leg, they should definitely wash their hands and change their gloves. As far as microwaving food, we do not check the temperature every time something comes out. They've been told to warm the vegetables for 90 seconds and soup for 180 seconds, but he could not verify how long the items were in the microwave.	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2011
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 04/21/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Becky Juggins, NNA *Administrator* *05/16/11*

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.