

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

PRINTED: 12/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

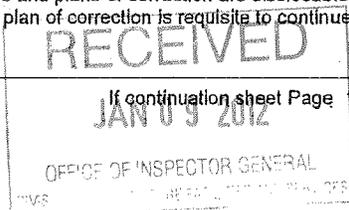
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000	Facility Administrator states that the plan of correction contained here- in constitutes the facility's allegation of compliance with all deficiencies cited, that no separate notification of compliance is required by virtue of this allegation of compliance, and that this allegation of compliance may presume the facility's compliance until substantiated by a revisit or other means.	
F 166 SS=D	<p>A standard health survey was conducted 12/06/11 through 12/08/11 and a Life Safety Code survey was conducted on 12/06/11 with highest scope and severity of a "E". The facility had the opportunity to correct deficiencies before penalties would be recommended for imposition. 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of Resident Rights, Complaint/grievance reports, and review of the facility's policy, it was determined the facility failed to keep the resident/family appropriately apprised of progress toward a resolution, for one (1) of twenty-four (24) sampled residents. The facility failed to act on concerns expressed by Resident #17's family regarding quality of care/treatment and a medication error during the months of October and November, 2011. There was no evidence the facility followed their policy and procedure related to grievance forms or actively sought a resolution to the resident/family's verbal grievances.</p> <p>The findings include:</p> <p>Review of the Residents Rights packet provided by the facility revealed residents and families are</p>	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE X Administrator	(X6) DATE X 01/06/12
---	--------------------------	-------------------------

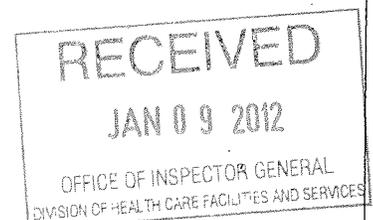
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

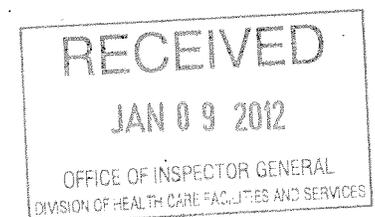
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 166	<p>Continued From page 1</p> <p>to use the internal grievance procedure and expect that all concerns be resolved promptly. Review of the facility's Grievances Policy and Procedure, effective date 10/19/10, revealed the procedure was to complete the grievance form or verbally report the complaint to the facility staff member, who would complete the grievance form, give a completed form to the social worker/designee or the administrator and the person who originated the complaint/ grievance will followed up promptly and keep the resident/family apprised of the progress toward resolution.</p> <p>Review of the Grievance/Concern log from July 2011 until November 2011 revealed no grievances or concerns reported.</p> <p>Review of the inservice records revealed a nurse aide meeting, on 10/18/10, revealed when a resident had a missing item or if they had any complaints about anything you, the staff, are to inform the nurse and you need to fill out the grievance form or the missing item form...follow the protocol to have the issue resolved...</p> <p>Review of Resident #17's clinical record revealed the facility admitted the resident on 07/11/11 with the following diagnoses: Mental Disorder, Pressure Ulcer Buttock, Cardiovascular Accident (CVA) and Type 2 Diabetes. The Quarterly Minimum Data Set (MDS) dated 09/17/11 assessed Resident #17, using the Brief Interview for Mental Status (BIMS), as severely impaired.</p> <p>Interview with Resident #17's family, on 12/08/11 at 9:00 AM, revealed concerns had been voiced to staff and administration regarding care and</p>	F 166	<p>F166</p> <p>The Social Services Director and Administrator will meet with the family of Resident #17 to review with them their concerns and discuss the resolution of those concerns. This will occur by 1/7/12.</p> <p>Social Services Director and ADON will review all 24 Hour Reports for the last 30 days to determine if there have been any concerns voiced but not followed up on. This will be completed by 1/10/12. Any issues noted will be addressed at this time.</p> <p>Administrator will interview all department directors to determine if any concerns have been voiced to them by families, staff or visitors that may need to be followed up on. This will be completed by 1/7/12.</p>		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

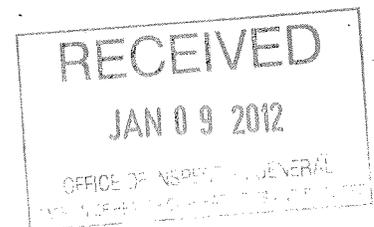
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 166	<p>Continued From page 2</p> <p>treatment. The family came in to visit on one occasion and the wrong tube feeding was infusing. In addition, the family stated they found Resident #17 with stool in the pressure ulcer wound. She had voiced her concerns to the floor staff, the East unit manager Licensed Practical Nurse (LPN) #5, Social Services, Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Administrator without resolutions.</p> <p>Interview with LPN #6, on 12/08/11 at 3:45 PM revealed she observed Jevity tube feeding infusing instead of Glucerna 1.2 on or around 10/05/11 and the floor supervisor was notified at the time. Continued interview with LPN #6 revealed, when the family voiced concerns she notified the unit manager, and upper management.</p> <p>Interview with the East Unit Manager LPN #5, on 12/08/11 at 3:55 PM, revealed the procedure regarding grievance are to address the concern or report concerns to the correct department. She was not familiar with the procedure for documenting concerns or grievances. She stated without a procedure there is no way to show a concern or grievance was addressed.</p> <p>Interview with the Director of Social Service, on 12/08/11 at 4:00 PM, revealed when she would see Resident #17's family she was possibly informed of a concern. She stated she would notify the department to follow up. There was no documentation regarding Resident #17's concerns on the grievance log. She was hired 05/11 and had not been trained on the grievance policy and procedure.</p>	F 166	<p>Administrator will review the Grievance Policy and Procedure with all Department Heads by 1/6/12 to ensure their thorough understanding of the process. The Staff Development Coordinator will present education on the Grievance Procedure to staff by 1/12/12. This education will be repeated monthly for 3 months then annually. All newly hired employees will be educated during orientation. The Social Service Director or Assistant will attend the next Resident Council Meeting to discuss with residents the Grievance Procedure. They will attend a meeting quarterly for 2 quarters to discuss the Grievance Procedure. Social Services or Assistant will also discuss the Grievance Procedure with those residents capable during their quarterly social service interview to ensure all</p>		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 166	Continued From page 3 Interview with the ADON, on 12/08/11 at 4:15 PM, revealed Resident #17's family was very particular regarding her/his care. She further revealed most of their complaints were derived from the second (2nd) and third (3rd) shift. There was no documentation on the grievance log that had been initiated for any complaints or concerns regarding Resident #17. Interview with the DON, on 12/08/11 at 5:30 PM, revealed the system for grievance was when there was a concern with residents, family, visitors or staff. She was knowledgeable of Resident #17's family's concerns of the incorrect tube feeding. She stated no written grievance had been written. The purpose of the grievance form was to find a resolution in a timely manner. Interview with the Administrator, on 12/08/11 at 6:00 PM, revealed he was aware of Resident #17's family's concerns/grievances via verbal communication from the family; however, acknowledged no written documentation on the grievance log. He had discussed in a department head meeting on 10/06/11 concerns from the family about the wrong tube feeding being used and had instructed the unit manager to follow up with the employee responsible and the family. He was unaware as of today, 12/08/11, that it had not been followed up on.	F 166	current residents receive the information. The Grievance Procedure will be discussed during the admission process for all new residents. The Social Service Director will conduct an audit of all grievances monthly X 3 months, then quarterly X 3 quarters to ensure compliance with reporting and resolution. The findings of the audits will be reported to the facility's Quality Assessment and Assurance Team to ensure compliance and determine if further corrective action is needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		01/13/12



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

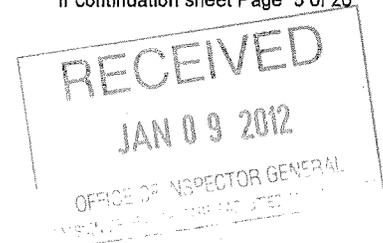
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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 279	<p>Continued From page 4</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a nursing care plan based on the Minimum Data Set (MDS) assessment for one (1) of twenty-four (24) sampled residents, Resident #4. The facility identified, in the admission MDS, Resident #4 was at risk for falls and was noted with cognitive impairment. However, failed to care plan either concern.</p> <p>The findings include:</p> <p>Record review of the facility's policy on the Nursing Care Plan (Effective 03/15/11) revealed a nursing care plan was vital and would be made</p>	F 279	<p>F 279</p> <p>The IDT Team will review the Care Plan for Resident #4 to ensure the care plan is current, the Nurse Aide Care Plan will be reviewed also to ensure accuracy. This will be completed by 1/12/12.</p> <p>The Interdisciplinary Team will review the most recent comprehensive MDS, CAA's and Care Plans to ensure that care plans are current, and all areas triggered have a care plan or explanation as to why a care plan was not developed. This will be completed by 1/12/12.</p> <p>Care Plan process and procedure will be reviewed with IDT and all licensed nurses utilizing the corporate education on the development of a care plan. This will be completed by 1/12/12 and be verified by the DON utilizing a sign-in sheet. DON and MDS Coordinator will review 25% of care plans monthly for 4 months, making sure each care plan is reviewed for a second time within the next 4 months to ensure the care plans are accurate and up to date. Any noted issues will be addressed at the time they are found. Any</p>	
-------	---	-------	--	--



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

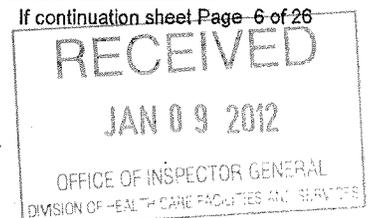
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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 279	<p>Continued From page 5</p> <p>as soon as possible after admission. Within five days the formal nursing care plan would be made. This plan of care would be dated and signed by the nurse that developed it. It also stated changes in physical and mental condition as observed by the nursing personnel would be added by the nurse. The plan of care would be kept current. However, use of the MDS was not included in the policy, which identified potential problems or concerns, in addition to the current problems and concerns.</p> <p>Record review of the admission MDS dated 02/09/11 for Resident #4 revealed the facility assessed the resident as at risk for falls. In addition, assessed Resident #4 with cognitive loss. On the admission BIM, the facility assessed the resident as severely, cognitively impaired.</p> <p>Record review of the care plan for Resident #4 revealed cognitive impairment not present on the care plan. The resident concern/problem of at risk for falls was missing from the care plan.</p> <p>Observation, on 12/07/11 at 10:15 AM, of Resident #4 in his/her room revealed the resident asked a nurse where he/she was and did his/her family know where he/she was. Resident #4 at the time was noted to be in a wheelchair with a prosthetic left lower leg and a partial amputation of the right foot.</p> <p>Interview, on 12/07/11 at 11:10 AM, with the MDS Lead Coordinator revealed the MDS staff wrote</p>	F 279	<p>comprehensive MDS completed for the next 3 months will be reviewed to ensure that all triggered areas are addressed in the care plan or an explanation is provided as to why a care plan was not developed.</p> <p>DON will report on audits of care plans no less than quarterly to the facility QAA Committee.</p>	01/13/12
-------	--	-------	---	----------



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

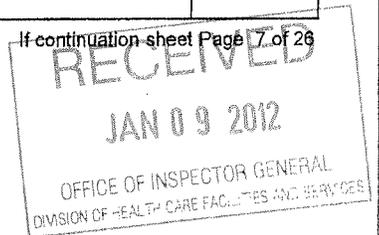
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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
--------------------	--	---------------	---	----------------------

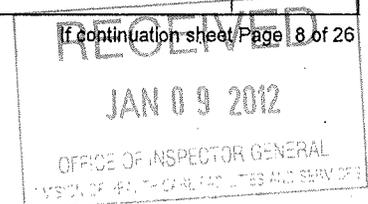
F 279	<p>Continued From page 6</p> <p>the initial admitting care plan for the resident based on their MDS assessment. Items that are triggered on the assessment as a concern are also included on the care plan as a potential problem or concern. A BIM score of five (5) to ten (10), would have made its way on to the care plan. If falls had triggered on the assessment, it would be on the care plan.</p> <p>Interview, on 12/08/11 at 2:20 PM, with MDS Coordinator #1 revealed the Care Area Assessment (CAA) from the MDS indicated what needed to be on the care plan for the resident. The CAA's, or triggers, reveal any issue which needed to be addressed, such as falls. She stated a trigger for falls would be expected to be on the care plan and, if it was not there, there should be an explanation why it was not care planned. She stated it could be detrimental to the resident if any issue that was identified by the CAA's was not on the care plan. She revealed she was accountable to the MDS Lead Coordinator but did not know if that person reviewed her work.</p> <p>Interview, on 12/08/11 at 4:30 PM, with MDS Coordinator #2 revealed the MDS coordinators wrote the initial care plan for the resident using the MDS assessment and the CAA's. She had training on the MDS through the company and hands on experience. No one person was responsible and accountable for the care plan. If something was missing from the care plan it could be "derogatory" to the health of the resident.</p>	F 279		
-------	---	-------	--	--



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

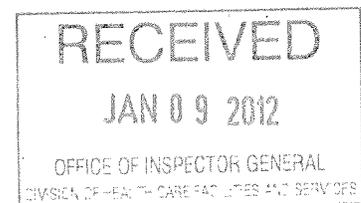
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 279	Continued From page 7 Continued interview, on 12/08/11 at 4:40 PM, with the Lead MDS Coordinator revealed there was not one person responsible for the care plan. She stated everybody was involved. If an item was not on the care plan that should have been there, the consequence to the resident was they would not get what they needed and something would be overlooked.	F 279		
F 280 SS=D	Interview, on 12/08/11 at 4:50 PM, with the Director of Nursing (DON) revealed the MDS Coordinators generate the initial care plan. She stated if falls and cognitive status had triggered in the assessment, they should be on the care plan. If falls are not on the care plan of a resident that had been assessed at risk, she stated they would be at risk for injury. The Assistant Director of Nursing (ADON) and she were responsible for monitoring. The facility was working on a system to monitor care plans but there was currently no system in place. 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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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,	F 280		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 280	<p>Continued From page 8</p> <p>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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to review and revise the care plan for two (2) of twenty-four (24) sampled residents (#9 and #19). The facility failed to remove from the care plan multiple interventions no longer applicable or resolved for Residents #9 and #19 rendering the care plans inaccurate.</p> <p>The findings include:</p> <p>Record review of the facility policy Nursing Care Plan (Effective 03/15/11) revealed the care plan would be kept current. It stated as goals were reached, or deemed unattainable, new goals would be added.</p> <p>1. Record review of the care plan for Resident #19 revealed four (4) problems which were resolved, but not noted as resolved. The problems were not updated and remained a part of the current care plan. On the Resident Acute Care Plan under the listing Skin Problems, Resident #19 had a skin tear on his/her left hand and right leg and a goal date to have the problem resolved as 05/06/11. An additional Acute Care</p>	F 280	<p>F280</p> <p>The Care Plans for Resident #19 and #9 will be reviewed by the Interdisciplinary Team by 1/10/12.</p> <p>The Interdisciplinary Team will review all Care Plans to ensure all current residents have a care plan that reflects the resident's needs. This will be completed by 1/12/12.</p> <p>Care Plan process and procedure will be reviewed with IDT and all licensed nurses utilizing the corporate education on the development of a care plan. This will be completed by 1/12/12 and verified by the DON utilizing a sign-in sheet. DON and MDS Coordinator will review 25% of care plans monthly for 4 months, making sure each care plan is reviewed for a second time within the next 4 months to ensure the care plans are accurate and up to date. Any noted issues will be addressed at the time they are found. Care plans are to be monitored daily by the Unit Managers to ensure updates are made as indicated. Acute Care Plans are to be reviewed no less than weekly by the IDT to ensure they are noted as resolved timely.</p>	



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

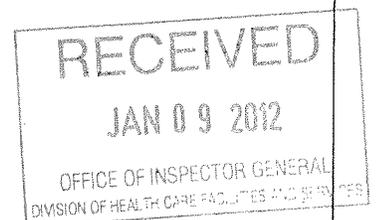
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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 280	<p>Continued From page 9</p> <p>Plan for Skin Problems listed an open area to the right ankle of Resident #19. The onset date was 06/03/11 and the goal date was 07/03/11. A skin tear to the right wrist was added to that care plan page on 09/01/11. Another active Skin Problem care plan was a skin tear to the right forearm of Resident #19 with an onset date of 10/27/11 and the date of "x 7 days" (in seven days) for a resolution. The current Nurses Skin Audit dated 11/28/11 revealed Resident #19 had old bruises on his/her upper and lower extremities. No open areas were listed on the skin assessment of Resident #19. In addition, there was a current Resident Acute Care Plan for UTI (Urinary Tract Infection) for Resident #19 with an onset date of 05/13/11 and a resolution target date of 05/23/11. Resident #19 did not currently have a UTI.</p> <p>Observation, on 12/08/11 at 10:55 AM, of the skin assessment for Resident #19 with LPN #3 revealed a small reddened area behind his/her right knee. No open areas were observed.</p> <p>Interview, on 12/08/11 at 2:00 PM, with Licensed Practical Nurse (LPN) #3 revealed the nurses would update the care plan as they "get new things" and the Unit Coordinator would monitor the care plan. She stated when she was hired she was shown how to update the care plan. It was revealed the care plan allows the resident to work toward goals and the staff can follow along with what the resident needs. Without the care plan, the residents would not receive the care they need and may have an adverse reaction.</p> <p>Interview, on 12/08/11 at 3:40 PM, with LPN #4 revealed skin tears would not go on the care plan. She stated skin injuries or skin tears were not</p>	F 280	<p>DON will report on audits of care plans no less that quarterly to the facility QA Committee.</p>	01/13/12
-------	---	-------	---	----------



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

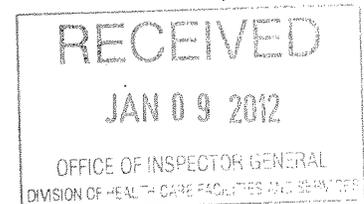
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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
--------------------	--	---------------	---	----------------------

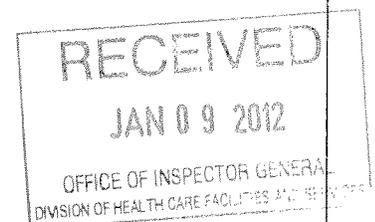
F 280	<p>Continued From page 10 care planned. It would be noted on the skin assessment, she said.</p> <p>Interview, on 12/08/11 at 4:15 PM, with LPN #1 revealed skin tears do go on the care plan, as do falls, wounds, risks and skin breakdown. A skin tear would be noted in the treatment book and on the Acute Care Plan. She revealed any part of the current care plan that was present would be considered an active problem. If the problem had been resolved, it should have been pulled from the active care plan. The MDS staff was responsible to make sure the care plan was current.</p> <p>Interview, on 12/08/11 at 4:35 PM, with Registered Nurse (RN) #1 revealed skin tears go on the care plan. She stated every nurse was responsible to update the care plan, that no one person was responsible.</p> <p>Interview, on 12/08/11 at 4:30 PM, with MDS Nurse #2 revealed no one person was responsible and accountable for the care plan. She stated her care plan training had been hands on and training through the company. Additionally, she stated if an item was missing from the care plan, it could be "derogatory" to the health of the resident. She did not know if the care plans were monitored.</p> <p>Interview, on 12/08/11 at 3:05 PM, with the West Unit Coordinator revealed updates to the care plan could be added by any nurse. He stated he monitors some of it. He stated he was over the falls program and if an intervention occurred, related to falls, it was placed on the care plan. He revealed the MDS staff was thought to be</p>	F 280		
-------	---	-------	--	--



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

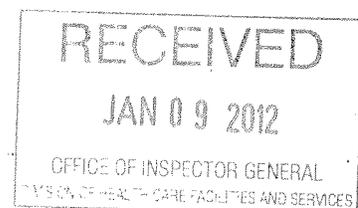
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 280	<p>Continued From page 11 responsible for the care plan.</p> <p>Interview, on 12/08/11 at 4:40 PM, with the MDS RN Manager revealed the staff on the units were responsible for the updates of the care plans. There is not one person responsible for the care plan. She stated if the care plan was not current, the residents would not get what they need.</p> <p>Interview, on 12/08/11 at 4:50 PM, with the Director of Nursing (DON) revealed the MDS department generates the initial care plan. Updates to the care plan were done by the person who identified the problem or concern. A skin tear would be on the care plan. The Unit Coordinator was responsible to monitor the care plans. The DON and Assistant DON monitored the Unit Coordinator. She revealed there was currently no system in place to assure the care plans were monitored.</p> <p>2. Record review of Resident #9 revealed the MDS dated 10/11/11 assessed Resident #9 as interviewable. Resident #9 did not trigger for falls and used a wheel chair as an assistive device.</p> <p>Observations, on 12/06/11 at 3:12 PM, 12/08/11 at 10:51 AM and 12/08/11 at 2:40 PM, revealed Resident #9 sitting in a wheelchair in his/her room unattended by staff.</p> <p>Record review of the Certified Nursing Assistants (CNA) Care Plan for December 2011, revealed Resident #9 was not to be left in room unattended while in his/her wheelchair.</p> <p>Interview with CNA #3, on 12/08/11 at 2:46 PM, revealed she noticed Resident #9 was in his/her room sitting in his/her wheelchair unattended and</p>	F 280		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

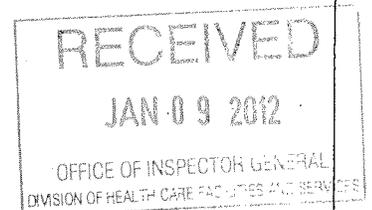
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 280	<p>Continued From page 12</p> <p>was not aware he/she was care-planned to not be left unattended while in wheelchair. CNA #3 further revealed she did not know why Resident #9 was care-planned to be monitored while sitting in his/her wheelchair in room.</p> <p>Interview with Registered Nurse (RN) #2, on 12/08/11 at 3:30 PM, revealed she was aware Resident #9 was not to be left in his/her room unattended while in wheelchair and was not aware Resident #9 had been left alone. RN #2 further stated the only explanation she could come up with, for the reason why Resident #9 should not be left in the wheelchair was so that Resident #9 would not self transfer his/her self out of the wheelchair. RN #2 stated, the nurses do not update the care-plan unless an order was obtained and the supervisors were responsible to update the care-plans.</p> <p>Interview with the Nurse Manager of the East wing, on 12/08/11 at 3:39 PM, revealed it was everyone's responsibility to update the care-plans and that she tried to keep them updated. Resident #9 was care-planned to not be left unattended in the wheelchair and this should have been discontinued from the plan of care. The Nurse Manager further stated orders were added daily to the care-plan and then updated quarterly.</p> <p>Interview with the Director of Nursing (DON), on 12/08/11 at 4:27 PM, revealed CNA care-plans were reviewed at the falls meetings to make sure interventions were followed. The DON further stated that Resident #9 has had no falls since the DON had been working at the facility for seven months and the care-plan should have been</p>	F 280		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

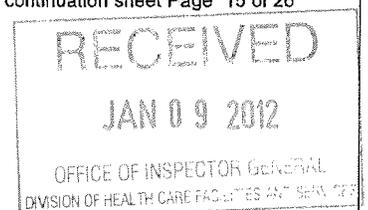
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 280	Continued From page 13 updated. The DON stated the CNA care-plan was not updated because the facility did not trigger Resident #9 for falls.	F 280		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	F 441 Resident #4, #5, and #6 have been monitored by ADON to ensure that the practice noted does not present any complications for the resident (infection, deterioration in wound, etc.) ADON will review all lab reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices. This will be completed by 1/10/12. All licensed and non-licensed nursing staff will be in-serviced by the Staff Development Coordinator on isolation precautions per the Lippincott Manual by 1/12/12. This education will be repeated monthly for 3 months then quarterly, all licensed and non-licensed employees must attend a minimum of 4 times within the next year. All newly hired employees will receive their initial education during orientation. All licensed staff providing direct care to residents will be in-serviced with return demonstrations on dressing changes, hand washing, and glove changes by 1/12/12. Housekeeping Director will	



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

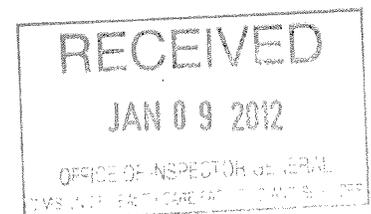
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 441	<p>Continued From page 14</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Center for Disease Control (CDC) Guideline for Hand Hygiene in Health-Care Settings, Mosby's Textbook for Long-Term Care, the facility's policy titled Hand Washing, and the facility's procedure for personal laundry care it was determined the facility failed to complete resident dressing changes per infection control guidelines for three (3) of the twenty-four (24) sampled residents (Residents # 4, #5, and #6). In addition the facility failed to maintain an effective infection control program as evidenced by improper transport of clean linen. This is a repeat deficiency.</p> <p>The findings include:</p> <p>1. Review of the CDC Guideline for Hand Hygiene in Health-Care Setting, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings; Change gloves during patient care if moving from a contaminated body site to a clean body site; Decontaminate hands after removing gloves.</p> <p>Review of Mosby's Textbook for Long-Term Care, copyright 2007, revealed gloves should be</p>	F 441	<p>re-educate housekeeping/laundry staff on the proper procedure for the transportation of personal linen by 1/12/12.</p> <p>ADON will observe each nurse complete a dressing change within the next 4 weeks or until all nurses have been observed completing a dressing change no less than two times. ADON will provide evidence of return demonstrations to DON for reporting to the facility QA committee. ADON will continue to track and trend infections and communicable diseases and report no less than quarterly to the next month and will report her findings to the facility QA Committee.</p>	01/13/12	



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011	
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 441	<p>Continued From page 15</p> <p>discarded and hands decontaminated after removal of a soiled dressing. Clean gloves should be applied prior to cleaning the wound and applying a clean dressing. Hands should be decontaminated before and after the procedure.</p> <p>Interview with the Director of Nursing, on 12/08/11 at 5:10 PM, revealed the Mosby's textbook was the reference book, available on the nursing units, utilized by the nursing staff.</p> <p>Review of the facility's policy Hand Washing, not dated, revealed Hands should always be washed after gloves are removed, even if the gloves appear to be intact.</p> <p>Observation of Resident #6's dressing change to the left foot, on 12/08/11 at 11:25 AM, revealed Licensed Practical Nurse (LPN) #4 removed the Residents soiled dressing, cleaned the wounds with normal saline, and reapplied Gelocast dressing without changing gloves and washing hands between steps. The LPN then applied Sarna lotion to both upper extremities, the left knee, and the right shin with the same pair of gloves used for the dressing change.</p> <p>Interview with LPN #4, on 12/08/11 at 2:30 PM, revealed she was aware she did not wash her hands between glove changes on Resident #4, but was not aware this was a problem. The LPN revealed she did not know the facility's policy on handwashing or CDC guidelines. Further interview with LPN #4 revealed she realized after the dressing was completed, she had not changed gloves, or washed her hands, during the dressing change on Resident #6. The LPN revealed both situations were potential problems</p>	F 441		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 441	<p>Continued From page 16 with infection control. The LPN stated she had not received an in-service or training on handwashing or dressing changes.</p> <p>2. Observation, on 12/07/11 at 11:00 AM, of the dressing change to the left heel of Resident #5 revealed Licensed Practical Nurse (LPN) #3 washed her hands prior to starting the dressing change. She then put on gloves to do the dressing change. The old dressing was removed and LPN #3 changed gloves. She did not wash her hands between glove changes. LPN #3 washed her hands when the dressing change was complete.</p> <p>Observation, on 12/08/11 at 11:35 AM, of the dressing change to the right foot of Resident #4 revealed LPN #4 washed her hands prior to the dressing change. She put on gloves to do the dressing change. The old dressing was removed and the wound cleansed with the same pair of gloves on. LPN #4 put on new gloves to place a clean dressing on the wound. No hand washing took place between glove changes.</p> <p>Interview, on 12/08/11 at 2:00 PM, with LPN #3 revealed the facility policy on hand washing for a dressing change was to wash your hands before you begin and when you have finished the dressing change. She stated she did not think you had to wash your hands between glove changes.</p> <p>Interview with the Director of Staff Development (DSD), on 12/08/11 at 4:20 PM, revealed he was responsible for orientation, in-services, and certified nursing assistant (CNA) hours. The</p>	F 441		



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

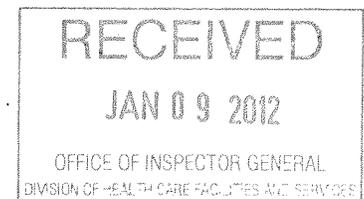
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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 441	<p>Continued From page 17</p> <p>DSD revealed infection control and handwashing are required in-services done twice a year. He further revealed dressing changes and aseptic technique were part of the employee orientation. The DSD revealed he was not aware infection control guidelines were not being practiced during dressing changes. He stated he made rounds to the nursing units and asked if there were concerns, but did not audit specific care areas in practice. The DSD revealed poor technique could lead to infections or ineffective healing. He further revealed there was no monitoring of dressing changes.</p> <p>Review of infection control in-service provided by the facility, dated 08/18/11, was titled CNA in-service program-current infection control issues and did not include nurses.</p> <p>Interview with the Director of Nursing (DON), on 12/08/11 at 5:10 PM, revealed she had been with the facility for seven (7) months and had not reviewed the previous statement of deficiency or plan of correction. The DON revealed she had monitored dressing changes and had made rounds, but was not aware infection control guidelines were not being followed during dressing changes. The DON revealed she did monitor to ensure the staff were not touching the residents food, covering the linen, and washing hands. However, the DON revealed there was no auditing tool utilized during rounds and monitoring. The DON revealed there was a potential for infection and stated she expected all of the staff to perform proper handwashing and maintain proper technique during dressing changes and between residents.</p>	F 441		
-------	---	-------	--	--



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

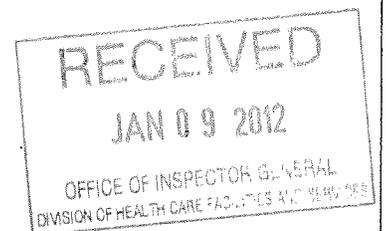
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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
--------------------	--	---------------	---	----------------------

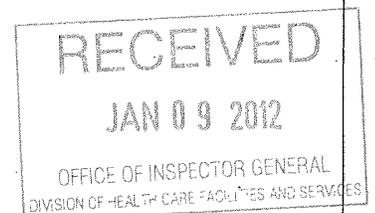
F 441	Continued From page 18 3. Record review of the facility's Procedure for Personal Laundry Services (No source listed, no review date noted) revealed resident laundry would be washed, folded, or clothes hung up, and delivered to the resident. However, placing a cover over personal laundry during delivery for the purpose of infection control was not included in the policy. Observation, on 12/08/11 at 11:25 AM, during the delivery of linen and resident laundry by Housekeeper/Laundry #1 on the west side of the facility revealed residents personal laundry was delivered on top of the bin used to deliver linen. The bin itself was covered. The personal laundry, however, was on hangers draped over the top of the cart uncovered. Interview, on 12/08/11 at 11:30 AM, with Housekeeper/Laundry #1 revealed she was to put a sheet over the top of the personal laundry to cover it during delivery. She had been trained on how to deliver the residents' laundry. In addition, the clothes were to be covered, as an infection control precaution, to keep anyone from touching the clothes and spreading germs. Interview, on 12/08/11 at 11:30 AM, with the Housekeeping Director revealed she had been trained on infection control as it applied to the laundry. The laundry, linen and resident clothing, were to be covered during transport to the floor and resident rooms. She stated it was the facility's standard of practice. If someone was touching the clothes during delivery it could spread germs or whatever.	F 441		
F 514	483.75(l)(1) RES	F 514		



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

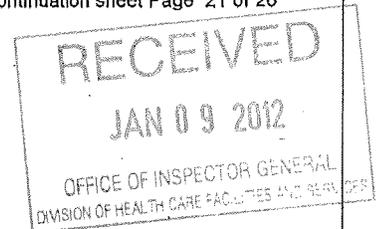
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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)
F 514 SS=D	<p>Continued From page 19</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the clinical record was accurately maintained for one (1) of twenty-four (24) residents (Resident #17). The facility obtained an order dated 09/13/11 for Resident #17 to receive continuous Glucerna 1.2 at fifty-five (55) ml/hr. However, on or about 10/06/11 on second (2nd) shift the family of Resident #17 observed Jevity 1.2 tube feeding infusing instead of Glucerna 1.2. The facility failed to ensure the medical record contained notification of the physician, documentation, assessment and follow up related to the wrong tube feeding being infused.</p> <p>The findings include:</p> <p>Review of the facility Medical Record Department Policies, undated, revealed the medical record</p>	F 514	<p>F514</p> <p>A Medication Error Report will be completed for Resident #17. Physician notification will be made and follow up with family will be completed. This will be completed by 1/10/12.</p> <p>Medication errors, reports of incidents and reports of injuries of unknown origin as well as the 24 hour reports for the last 30 days will be reviewed by the DON and ADON to ensure all proper notifications were made, and that documentation of each is included in the medical record. This will be completed by 1/12/12.</p> <p>The Staff Development Coordinator, along with the Director of Nursing will provide in-services regarding proper documentation, including medication errors, incidents, injuries of unknown origins, change in condition, new diagnosis, to the Nursing Staff. The corporate presentation on documentation will be used. This will be completed by 1/12/12 and repeated monthly for 2 months then annually. All newly hired licensed staff will be educated during orientation.</p>



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

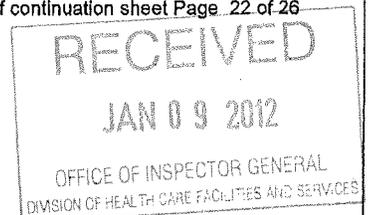
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 514	<p>Continued From page 20</p> <p>consists of sufficient data recorded in sequence of events to justify the diagnosis and warrant treatment and end results. Further review of the facility Medication Errors and Drug Reactions revealed the documentation should include date, time of error, explanation of medication error in detail, notification of physician and notify resident and resident's representative per facility policy.</p> <p>Review of Resident #17's clinical record revealed the facility admitted the resident on 07/11/11 with the following diagnoses: Type 2 Diabetes, Mental Disorder, Pressure Ulcer Buttock, Cardiovascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 09/17/11 revealed the facility assessed Resident #17 as severely impaired.</p> <p>Review of the Nurses Note on 10/04-10/07/11 revealed no assessment, intervention or physician notification regarding Resident #17 receiving incorrect tube feeding.</p> <p>Interview with Licensed Practical Nurse LPN #6, on 12/08/11 at 3:45 PM, revealed she observed Jevity 1.2 tube feeding instead of Glucerna 1.2. She stated there was no Medication Error and Drug Reaction report initiated.</p> <p>Interview with East Unit Manager LPN #5, on 12/08/11 at 3:55 PM, revealed receiving the wrong tube feeding would be a medication error. She further revealed no medication error or incident report was filed.</p> <p>Interview with the Assistant Director of Nursing, on 12/08/11 at 4:15 PM, revealed no knowledge of the wrong tube feeding on Resident #17. She further stated a medication error report should</p>	F 514	<p>DON and ADON will review all medication errors, reports of incidents, injuries of unknown origins and 24 hour reports weekly for 4 weeks then monthly for 3 months to ensure appropriate documentation is included in the medical record and that the corporate guidelines related to documentation are being followed. These audits will be reported to the facility QAA Committee for review.</p>	01/13/12	



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

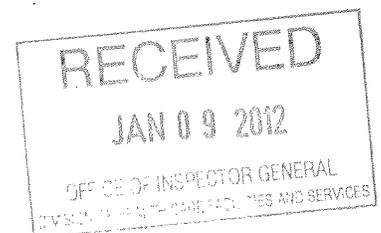
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 514	Continued From page 21	F 514		
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have an effective Quality Assurance (QA) committee to ensure ongoing compliance of corrected deficiencies.</p>	F 520	<p>F 520</p> <p>The Social Services Director and Administrator will meet with the family of Resident #17 to review with them their concerns and discuss the resolution of those concerns. The IDT Team will review the Care Plan for Resident #4 to ensure the care plan is current, the Nurse Aide Care Plan will be reviewed also to ensure accuracy. Resident #4, #5, and #6 have been monitored by ADON to ensure that the practice noted does not present any complications for the resident (infection, deterioration in wound, etc.) The Care Plans for Resident #19 and #9 will be reviewed by the Interdisciplinary Team. The Interdisciplinary Team will review all Care Plans to ensure all current residents have a care plan that reflects the resident's needs.</p> <p>Social Services Director and ADON will review all 24 Hour Reports for the last 30 days to determine if there have been any concerns voiced but not followed up on. Any issues noted will be addressed at this time. Administrator will interview all</p>	



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 520	<p>Continued From page 22</p> <p>The facility was cited with repeat deficiencies related to grievances, development of comprehensive plan of care, and infection control from the 2010 survey.</p> <p>The findings include:</p> <p>Review of the facility policy Quality Assessment and Assurance (QA&A), effective 05/01/2008, revealed the QA&A is a process that is ongoing, multi-level and facility wide. Its purpose is evaluation of facility systems with the objectives of....correcting inappropriate care processes.</p> <p>Review of the QA signature sheet revealed the facility conducted QA meetings at least quarterly with the required members.</p> <p>Observation during the course of the survey 12/06-12/08/11, revealed deficient practice was found with issues regarding, following facility policy related to following up on grievances. Refer to F166. Deficient practice was found regarding, development of comprehensive care plans for Cognition and Falls. Refer to F279. Deficient practice was found regarding following facility policies to maintain compliance in areas that would prevent cross-contamination during wound dressing changes. Refer to F441.</p> <p>1. Interview with the East Unit Manager LPN#5, on 12/08/11 at 3:55 PM revealed the procedure regarding grievance are to address the concern or report concerns to the correct department. She further revealed she was not familiar with the procedure for documenting concerns or grievances. She stated without a procedure there is no way to know if a concern or grievance were</p>	F 520	<p>department directors to determine if any concerns have been voiced to them by families, staff or visitors that may need to be followed up on.</p> <p>The Interdisciplinary Team will review the most recent comprehensive MDS, CAA's and Care Plans to ensure that care plans are current, and all areas triggered have a care plan or explanation as to why a care plan was not developed.</p> <p>ADON will review all lab reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices.</p> <p>The QAA Committee, along with the Medical Director will meet by 1/10/12 to review the current Statement of Deficiencies , including Infection</p>		



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

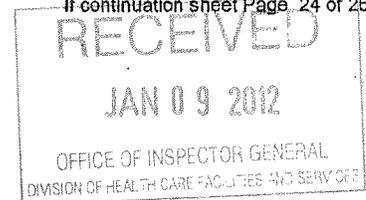
PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
---	--

(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
--------------------	--	---------------	---	----------------------

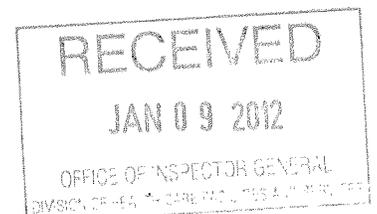
F 520	<p>Continued From page 23 addressed.</p> <p>Interview with the Director of Social Service, on 12/08/11 at 4:00 PM, revealed she was hired 05/11 and had not been trained on the grievance policy and procedure.</p> <p>2. Interview, on 12/07/11 at 11:10 AM, with the MDS Lead Coordinator revealed the MDS staff wrote the initial admitting care plan for the resident based on their MDS assessment. Items that are triggered on the assessment as a concern are also included on the care plan as a potential problem or concern.</p> <p>Interview, on 12/08/11 at 4:50 PM, with the Director of Nursing (DON) revealed the MDS Coordinators generate the initial care plan. She stated if falls and cognitive status had triggered in the assessment, they should be on the care plan. The facility was working on a system to monitor care plans; however, there was currently no system in place.</p> <p>3. Interview with LPN #4, on 12/08/11 at 2:30 PM, revealed she stated she had not received an in-service or training on handwashing or dressing changes.</p> <p>Interview with the Director of Staff Development (DSD), on 12/08/11 at 4:20 PM, revealed he is responsible for orientation, in-services, and certified nursing assistant (CNA) hours. The DSD revealed infection control and handwashing are required in-services done twice a year. He further revealed dressing changes and aseptic technique were part of the employee orientation. The DSD revealed he was not aware infection</p>	F 520	<p>Control Policies, Grievances Polices , Care Plan Policies and Plan of Correction. Specific sub- committee members will be assigned to monitor and ensure the POC is implemented timely and completely. A subcommittee of QAA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective, the subcommittee will recommend changes to the full QAA Committee which will continue to meet no less than quarterly.</p> <p>The facility's Corporate Consultant will monitor the progress and compliance of the subcommittee with the implementation of the POC, and report to the VP of Operations any concerns no less than quarterly.</p>	01/13/12
-------	---	-------	---	----------



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

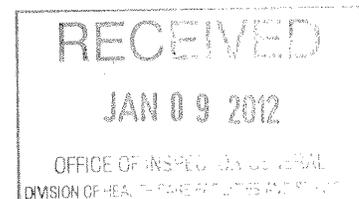
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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)
F 520	<p>Continued From page 24</p> <p>control guidelines were not being practiced during dressing changes. He stated he did make rounds to the nursing units and asked if there were concerns, but did not audit specific care areas in practice. The DSD revealed poor technique could lead to infections or ineffective healing. He further revealed there was no monitoring of dressing changes.</p> <p>Review of infection control in-service provided by the facility, dated 08/18/11, was titled CNA in-service program-current infection control issues and did not include nurses.</p> <p>Interview with the Director of Nursing (DON), on 12/08/11 at 5:10 PM, revealed she had been with the facility for seven (7) months and had not reviewed the previous statement of deficiency or plan of correction. The DON revealed she had monitored dressing changes and had made rounds, but was not aware infection control guidelines were not being followed during dressing changes. She did monitor to ensure the staff were not touching the residents food, covering the linen, and washing hands. However, the DON revealed there was no auditing tool utilized during rounds and monitoring. The DON revealed there was a potential for infection and stated she expected all of the staff to perform proper handwashing and maintain proper technique during dressing changes and between residents.</p> <p>Interview with the administrator, on 12/08/11 at 7:30 PM, revealed he took over the position (4) months ago and was familiar with the deficiencies from that survey. He stated the facility has had weekly meetings and monthly QA&A meetings</p>	F 520	
(X5) COMPLETION DATE			



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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 520	Continued From page 25 with all department heads and the physician. He stated they had completed all requirements and reports to QA that was listed on the Plan of Correction. Regarding the grievance deficiency, he felt like they had followed up on the families concerns for Resident #17's care issues but was not aware the unit manager had not followed up with the staff or family related to the tube feeding. Regarding the deficiency for Care Plans, he stated he was surprised they had an issue with that because they had done weekly audits and found no concerns.	F 520		



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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2011
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1986, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator, Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/06/11. North Hardin Health and Rehabilitation was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.