

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

PRINTED: 03/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185180 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                               | (X3) DATE SURVEY COMPLETED<br><br>03/07/2013 |
|---|--|--|--|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>NORTH HARDIN HEALTH & REHABILITATION CENTER     |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>599 ROGERSVILLE RD.<br>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<br><br>A standard health survey was initiated on 03/05/13 and concluded on 03/07/13 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 03/06/13 with no deficiencies cited. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.  | F 000  | F-241<br><br>1. Staff assigned to feed resident #17 and #19 were re-educated on not leaving residents sitting without food while others were eating. They were instructed to gather additional staff or have residents not attend the meal until their assigned time to eat. C.N.A #1 and LPN #3 were re-educated on remaining seated when assisting residents with meals. Education included dignity and respect for the residents who now required additional assistance. This education and instruction was completed by the Unit Manager, ADON, and DON.   |                               |  |
| F 241<br>SS=E   | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure staff assisted dependent residents in a dignified manner during meals in one (1) of two (2) nursing units. Facility staff allowed dependent residents to sit unassisted for up to 30 minutes during four (4) meal services on the East unit while other residents were served their meal. Staff were observed to be standing over the residents during the meal service while assisting the residents to eat. In addition, the facility failed to ensure residents wore clothing that was clean and good repair for one (1) of twenty-four (24) sampled and three (3) unsampled residents (Unsampled C).<br><br>The finding include: | F 241  | 2. Dining areas, including resident rooms, were monitored on 03/08/13, 03/11/13-03/15/13, 03/18/13-03/22/13, and 03/25/13-03/28/13 to ensure staff remained seated while feeding residents. The areas were monitored by DON, ADON, Unit Managers, Social Services, MDS Staff, and Unit Secretary's. Residents were monitored coming in and out of dining areas for soiled or tattered clothing and issues were addressed immediately by changing resident's clothing. Resident's with torn or irreparable clothing have had clothing removed and guardians have been informed to bring additional clothing for resident. Resident rooms were audited by DON and Assistant Administrator, | Completion by :<br>04/19/2013 |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE               |  | TITLE  |  | (X6) DATE                     |  |
|  |  | Administrator  |  | 4-1-13                        |  |

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 241   | Continued From page 1<br><br>Review of the facility's policy regarding Restorative Dining Program, undated, revealed it was the right of every resident to receive the necessary care to attain the highest mental, physical, and psychosocial well-being possible. The policy stated well trained staff were available with sufficient time at meals to carry out the task. Restorative dining was designed to provide a continuum of care for residents who may benefit from individualized attention and supervision.<br><br>Interview with the Director of Nursing, on 03/07/13 at 3:50 PM, the facility did not have a policy for assisting residents during meals.<br><br>Review of the census matrix and the dining assistance required for the the East unit dining room revealed there were 71 residents. For the Restorative dining, ten residents were assigned with eight residents that must be fed by staff and two residents required minimum assist. The East TV room had fifteen (15) residents with seven (7) residents that must be fed and seven (7) residents that required minimum to moderate assist.<br><br>1. Observation, on 03/05/13 at 8:20 AM, of the Restorative dining area revealed ten (10) residents in the room with two (2) staff. At 8:40 AM there were two (2) Residents (Resident #17 and Resident #19) sitting in the dining room. The residents' trays remained on the cart while the two (2) staff were feeding two (2) other residents each.<br><br>Interview during the Group meeting, on 03/05/13 | F 241  | To ensure that every resident room has a high back chair available. An Audit of 100% of the rooms was initially completed on 03/27/2013.<br>All dining areas have been audited by DON, ADON, Assistant Administrator and Unit Managers to determine the correct number of chairs are available in dining areas. This was completed 03/29/2013.<br><br>3. Education is being provided on the location of additional chairs if dining area chairs are occupied. This will be included in the staff education that started 03/25/2013.<br>Meal schedule is being changed to provide 2 different seating times in each dining area, excluding the Green Dining Room. This will be done by Unit Managers, Don, ADON, and Assistant Dietary Director and Dietary Director. Residents will enter dining areas at scheduled times. This will ensure dependent residents are not sitting unassisted during meal times. This will include and alternating schedule for nurses, on both units, during meal time. Each nurse will have an assigned dining area to assist with meals. Dining areas include: Unit TV rooms, Unit Sunrooms, and restorative dining room. Green Dining room will have dining times posted outside the dining room. Dietary will have a resident seating time and chart to deliver meals according to that schedule. Meals will be passed according to tables | Completion by :      |  |

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| F 241   | Continued From page 2<br>at 11:15 AM, revealed one (1) of eight (8) residents in attendance stated meals were served late and they had addressed it with the Administrator. One resident stated it would get better for a couple of days then go back to the same thing. He/she also complained the residents at the same table are not always served together, resulting in some residents watching the others at the table eating.   | F 241  | To ensure that residents dining together will have meal trays at the same time. The ADON will be in charge of updating the meal seating arrangement weekly and posting in designated areas in each dining area. This is effective 04/08/2013. Licensed and non-licensed nursing staff will be re-educated by DON, ADON, Staff Development, Unit Managers and house Supervisor, beginning 04/01/2013, on expectations during meal time. This education includes sitting while feeding, promoting a peaceful, non-hurried atmosphere and providing a dignified dining experience. The education extends to the quality and cleanliness of resident/patient clothing, to ensure clothing is clean and free from tears or holes before and after meals. This includes assisting residents with removing food particles from lap area after each meal and ensuring clothing is changed as needed before and after meals. Re-education staff on proper tray passing to ensure all residents at a table have their trays before beginning to pass trays at another table. This education will be repeated monthly for 3 months, then quarterly for 3 quarters and annually by the Staff Development coordinator, ADON or Unit Managers. All Newly hired licensed and non-licensed staff will be trained during orientation by Staff Development Coordinator. A collaborative post-test will be included to evaluate staff comprehension. |  |
|   | Observation, on 03/05/13 at 12:35 PM, of the main dining room revealed four residents were at one (1) table with two (2) residents eating while the other two (2) were still waiting.<br><br>Observation, on 03/05/13 at 12:35 PM, of the Restorative Dining area revealed ten (10) residents with two (2) residents feeding themselves and another resident eating an orange peel. Further observation revealed one (1) resident had a family member assisting him/her while two (2) staff were feeding two (2) residents each. Three (3) residents were sitting in the dining room waiting to be assisted with their meal while their trays remained on the tray cart.<br><br>Interview with Restorative Aide #1, on 03/05/13 at 12:35 AM, revealed the trays were delivered at 12:00 PM. She stated they usually had two (2) and occasionally three (3) staff to assist the residents.<br><br>Observation of the East dining room, on 03/08/13 at 8:45 AM, found sixteen (16) residents with four (4) Certified Nursing Assistants (CNA's) passing trays and assisting residents. There was four (4) residents at one (1) table and one (1) of those was eating breakfast. A CNA retrieved another of |  |   | Completion by:<br>04/19/2013                 |

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| F 241   | Continued From page 3<br>the four (4) residents' trays and sat down to feed that resident, while the other two (2) residents remained seated without being served at the same table.<br><br>Observation, on 03/06/13 at 12:00 PM, of the restorative dining room revealed trays were served with three (3) staff assisting six (6) residents to eat. One (1) resident was observed to be feeding himself/herself. Resident #17 was in the restorative dining room until 12:20 PM before being served his/her meal.<br><br>Observation, on 03/07/13 at 8:00 AM, during breakfast revealed the tray cart was arrived at 8:00 AM. By 8:20 AM all ten (10) residents assigned to the restorative dining were in the dining room. There were three (3) staff assisting six (6) residents. Two (2) residents who required assistance with feeding remained waiting in the dining room until 8:30 AM when they received their trays.<br><br>Interview, on 03/07/13 at 10:05 AM, with CNA #5 revealed staff get their assignments every day which tells them what the dining assignment would be for the day. She stated staff was to help with passing trays in all area's until their assigned area cart came out to the floor. She stated there was usually 2-3 CNA's assigned to the East TV room. She stated there was about six (6) residents that needed to be fed and four (4) more needed cuing and assistance. She stated some residents had to wait to get their meal, especially if there was only 2 CNA's in the dining room. She stated that's when the nurses should pick up and help. She stated the facility had a couple of meetings and talked about the nurses helping out | F 241  | 4. Dining areas will be monitored for standing staff while feeding, quality and cleanliness of resident clothing, and meals being served appropriately by table. Observation will be done by DON, ADON, Unit Managers, Director of Dietary, Assistant Director of Dietary, Social Services, and Unit Secretary's for 5 meals per week for 3 months; then 3 meals per week for 6 months; then 1 meal per week for 3 Months. Findings will be reported to QA Committee no less than quarterly for one year. Resident rooms will be audited to ensure a chair is available in every room beginning with one (1) hall each month for 8 Months; then 25% of rooms per hall every month for 4 months by DON, ADON, Assistant Administrator, Unit Secretary's, unit Managers and House Supervisor. The audit findings will be reported to the QA Committee no less than Quarterly for one year. |  |

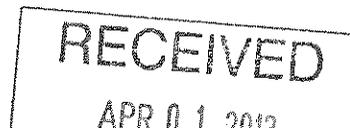
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| F 241   | Continued From page 4<br>more during meal time; but nothing had changed. She stated it was not acceptable for residents to have to wait to get their meal. She went on to say it was not fair for some residents to have to wait in the dining room to be served their meal just because they cant speak or were confused.<br><br>Observation during four (4) meal services, on 03/05/13 at 12:35 PM, on 03/06/13 at 8:45 AM and 12:00 PM, and 03/07/13 at 8:00 AM, revealed only one (1) nurse (Assistant Director of Nursing, ADON) assisted with tray pass or feeding residents on the East unit. A nurse from the West unit was observed to help with tray pass in the main dining.<br><br>Interview with Licensed Practical Nurse (LPN) #1, on 03/07/13 at 10:15 AM, revealed the Unit Coordinator made the daily assignments. She stated the nurses didn't have an assignment for meal service. She stated if there was enough CNA's to feed all the residents when the trays come up then the nurses didn't help with meal service. She stated the last time she helped in the dining rooms was on Tuesday in the main dining room. She denied they had a staff meeting about the nurses helping out with feeding the resident. She stated the residents should not have to wait more than five minutes to be served their meal. She stated the only nurse assigned for dining was a nurse from the West unit to go to the main dining room for meals to help with tray pass.<br><br>Interview with LPN #7, on 03/07/13 at 10:25 AM, revealed she believed that if there was seven (7) or more CNA's scheduled on the floor they could handle the meals. She stated all residents in the | F 241  |   |                      |  |



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| F 241   | Continued From page 5<br>restorative dining need to be fed and 95% of the residents in the East dining can feed themselves. She stated they had three (3) CNA's in the Restorative dining room to feed residents. She stated it was not possible for a CNA to feed three (3) residents at one time; but didn't believe all the residents were in the dining room at the same time. She stated it was not right for residents to have to sit and watch other residents eating when they are hungry.<br><br>Interview with the East Unit Manager, on 03/07/13 at 10:40 AM, revealed she had been at the facility three (3) weeks. She stated they had four (4) nurses on the halls and a desk nurse in addition to her, assigned on the East unit. She stated the nurses had not had an assignment for dining service in the past. She stated the residents should not have to wait to be fed and the CNA's can only feed two (2) residents at a time.<br><br>Interview with the ADON, on 3/07/13 at 10:50 AM, revealed she was responsible for restorative dining. She stated the CNA's had complained about having too many residents to feed. She stated the CNA's should not have to feed more than two (2) residents at a time. She stated she did not know how many residents on the East unit required total assistance with meals. The ADON went on to say she had been trying to get the nurses to be more involved with passing trays and meal service but stated they were usually passing medication during meals. She stated residents should not have to wait to get their meals. | F 241  |   |                      |  |

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| F 241   | Continued From page 6<br>2. Observation of lunch in the East Dining Room, on 03/07/13 from 12:54 PM to 1:15 PM, revealed Certified Nursing Assistant (CNA) #1 standing over Resident #3 feeding the resident lunch and Licensed Practical Nurse (LPN) #3 standing over Unsamped Resident C feeding the resident lunch.<br><br>Interview with CNA #1, on 03/07/13 at 2:10 PM, revealed she was supposed to be sitting while feeding residents as it could make residents' feel nervous and affect how much they ate. The CNA revealed there were no chairs available in the dining room at that time so she went ahead and fed the resident while standing up. The CNA revealed there were more people assisting with the meal service then usual and all the chairs were occupied. However, the CNA revealed she did not attempt to find another chair.<br><br>Interview with LPN #3, on 03/07/13 at 2:00 PM, revealed she should have been sitting while assisting the resident with their meal. The LPN revealed standing over a resident while they ate could be intimidating to the resident. The LPN revealed there were no available chairs in the dining room at the time of the meal service.<br><br>Interview with the East Unit Manager, 03/07/13 at 2:30 PM, revealed she had been at the facility for three (3) weeks. The East Unit Manager revealed staff should not be standing while assisting the residents with meals. The East Unit Manager revealed more help was needed during the meal service; however, there are enough chairs on the unit that the staff could have sat down. | F 241  |   |                      |  |

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| F 241   | Continued From page 7<br>Interview with Staff Development, on 03/07/13 at 3:40 PM, revealed the facility did not provide training on meal service or assisting residents with meals. The Staff Development revealed residents would not feel comfortable and they might feel rushed or hurried with their meal with staff standing over them while they attempted to eat.  | F 241  |   |  |
|   | Interview with the Director of Nursing (DON), on 03/07/13 at 3:50 PM, revealed staff should sit while assisting residents to prevent issues with dignity. The DON revealed she was not aware if the facility provided training or if the facility had a standard of expectation regarding meal service. The DON revealed she thought this was a technique taught in training programs and was common sense and did not think it would be an issue.<br>3. Observation during Initial Tour, on 03/05/13 at 8:30 AM, revealed a Certified Nursing Assistant (CNA) was standing up while assisting with feeding Resident #18. No chairs were observed in Resident #18's room at that time.<br><br>Interview with CNA #3, on 03/07/13 at 3:01 PM, revealed she thought staff should sit down next to residents when helping them eat. CNA #3 stated it could make the resident feel uncomfortable to stand next to them while eating.<br><br>Interview with Licensed Practical Nurse (LPN) #5, on 03/07/13 3:29 PM, revealed staff should not feed resident standing up, it would be more personable to feed them sitting down.<br><br>4. Observation, on 03/06/13 at 8:25 AM, revealed |  |   |  |

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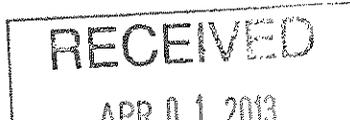
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| F 241   | Continued From page 8<br>Unsampled Resident C was up in the wheelchair in the hallway. The resident was found to have, what appeared to be a dried, whitish, pale yellow food particles about 3 centimeters in diameter on the upper left thigh area of the navy blue sweat pants.<br><br>Observation, on 03/06/13 at 12:50 PM, revealed Unsampled Resident C continued to have on the same pants with food debris still in place.  | F 241  |   |                      |  |
| F 279<br>SS=D   | Interview with the Family of Resident #17, on 03/07/13 at 09:45 AM, revealed the visitor came every day. He/she stated they had come in a couple of times and found dried food particles on the residents face and shirt. He/She stated they had not reported it; but just cleaned the resident up.<br><br>Review of the medical record for Resident #17 revealed the resident was admitted on 04/18/11 with Diagnosis of Cerebral Vascular Accident with Right Side Paralysis and Inability to Speak. Review of the Annual Minimum Data Set (MDS), dated 12/02/13, revealed the resident required total assistance grooming and mobility.<br><br>Interview with the East Unit Manager, on 03/07/13 at 10:40 AM, revealed it was unacceptable for a resident to have soiled, torn clothing on. She stated it was a dignity issue.<br>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279  | F-279<br>1. Resident #1 continuous refusal of care was Care Planned on 03/07/2013 by Social Services. Social Services discussed a |                      | Completion by:                               |



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| F 279   | Continued From page 9<br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, it was determined the facility failed to develop a comprehensive care plan that addressed refusal of care and dietary needs/devices for two (2) of twenty-four (24) sampled residents and three (3) unsampled residents, Resident #1 in regards to refusal of care and Resident #15 in regards to dietary needs and devices.<br><br>The findings include:<br><br>No policy could be provided on initiating a care plan. Interview with the Director of Nursing (DON), on 03/07/13 at 3:50 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) manual as the facility's policy and procedure for developing a comprehensive | F 279  | Psychiatric evaluation with resident #1 and family and they denied the services. Resident #15 adaptive equipment, consisting of Sippy Cups and scoop plate for meals, was specified on Care Plan on 03/18/2013 by Unit Manager.<br>2. Care Plan audit of all resident's with adaptive equipment was conducted to ensure that specific adaptive equipment is listed on Care Plan. This was completed by DON and MDS Staff from 03/08/13-03/18/2013.<br>Caretracker documentation, regarding refusal of care, has been audited on all residents to ensure refusal of care Care Plans are in place as needed. This was completed by the DON and MDS staff on 03/29/2013.<br>3. MDS Staff, Dietary Manager and Assistant Dietary Manager, received education on adding specific adaptive equipment to Care Plans on 03/18/2013 by DON and ADON. Dietary Staff are being re-educated on providing a different 2-handled cup with lid for each beverage on the meal tray when that type of cup is ordered. In-service will begin 04/01/2013 and be presented by Dietary manager, Assistant Dietary manager or Registered Dietician. Staff Development Coordinator will be responsible for educating new employees during orientation. Licensed nursing staff will be re-educated on writing specific adaptive equipment on Care Plans. |                      | Completion by:<br>04/19/2013                 |



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| F 279 | Continued From page 10 plan of care. | F 279 | Both licensed and non-licensed staff will be re-educated to ensure proper adaptive equipment is in place when passing trays. This will be presented by DON, ADON, Staff Development, Unit managers and House Supervisor beginning 04/01/2013. Staff will complete a post-test after the |  |
|-------|--------------------------------------|-------|---|--|

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|  | <p>Review of the MDS 3.0 Manual, Chapter 4, Section 4-6, page 4-8, revealed facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions. Section 4-7, page 4-10, revealed the care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths and needs. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with current practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well-developed and executed assessment and care plan looks at each resident as a whole human being with unique characteristics and strengths; and provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being.</p> <p>1. Observation of Resident #1, on 03/05/13 at 3:38 PM, revealed the resident was refusing to take a shower in the shower room.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/19/11 with diagnoses of Rehab Services, Congestive Heart Failure, Hypertension, Mental Disorder, Ischemic Heart Disease, Aortic</p> |  | <p>education to evaluate understanding. Tests will be reviewed by DON, ADON, and Staff development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed and non-licensed staff will be educated during orientation by the Staff Development Coordinator. Staff Education will be provided for all licensed staff that participates in the care planning process beginning 04/01/2013. Staff will be educated on the facility practice of charting on any resident that refuses care; to include refusing treatments, medications, bathing, eating, ect. They will also learn to report such incidents to Social Services for follow up if needed. This will be presented by Don, ADON, Staff Development, Unit Managers, and House Supervisor beginning 04/01/2013. Nurse's will complete a Post-test after education to evaluate understanding. Tests will be reviewed by DON, ADON, and Staff Development. This education will be repeated quarterly for 3 quarters and annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator.</p> |  |
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| F 279   | Continued From page 11<br>Coronary Bypass, Cardiac Pacemaker, Late Effects Hemiplegia, and Hyperlipidemia. Review of the Quarterly MDS, dated 01/10/13, revealed Resident #1 had a BIM score of 13, which meant the Resident was interviewable.<br><br>Review of the plan of care revealed there was no care plan to address the resident's refusal of care.   | F 279  | 4. The DON, ADON, Unit Managers or Unit Secretary's will observe a minimum of 5 meals per week for 3 months to ensure proper adaptive equipment is in place on meal trays. Observation of meals will continue with 3 meals per week for six months and then 1 meal per week for 3 months.<br>The finding will be reported to the QA Committee no less than quarterly for one year.<br>MDS Staff, Assistant Dietary Manager and Dietary Manager will audit care plans to ensure adaptive equipment is written correctly. This will be done with every Quarterly and Annual MDS Assessment and during Care Plan meetings quarterly, for no less than a year. Findings will be reported to QA Committee no less than quarterly for one year. A 25% audit of Caretracker documentation in regards to refusing care will be done monthly for 6 months and then quarterly for 2 quarters to ensure that Care Plans are in place for refusal of care. This will be done by DON, ADON, Assistant Administrator, Unit Managers, Staff Development, Social Services and MDS Staff. Findings will be reported to Social Services Director and reported to the QA Committee no less than quarterly for one year. |  |
|   | Review of the nursing notes, dated 12/16/12 at 6:00 PM, revealed the family was aware the resident was pulling off dressings and refusing to wash his/her hands or allowing staff to wash his/her hands. Nursing notes, dated 12/21/12 at 12:30 PM, revealed Resident #1 was up in the wheelchair, sitting with his/her brief on and refusing to get dressed. The nursing notes, dated 12/25/12 at 9:00 PM, revealed Resident #1 was refusing to allow bandages to be changed on his head. The resident was unhappy with the Certified Nursing Assistant (CNA) for changing the bedding and cleaning room. The CNA explained all bedding and dirty clothes had to be changed, after much debate, the resident allowed the CNA to clean him/her up. The resident still refused to have the bandages changed to the head. The nursing notes, dated 12/30/12 at 2:00 PM, revealed Resident #1 was refusing to have head wounds cleaned and the dressing applied. The nursing notes, dated 12/30/12 at 9:36 PM, revealed Resident #1 was still refusing all treatments and the resident was educated on the importance of the dressing changes to his scalp. The nursing notes, dated 01/07/13 at 1:00 PM, revealed the resident was refusing dressing changes. Further nursing notes, dated 01/07/13 at 4:30 PM, 7:45 PM and 10:00 PM, revealed the |  |  | Completion by :<br>04/19/2013                |

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| F 279   | Continued From page 12<br>resident refused dressing changes as ordered.<br><br>Review of the Social Services notes, dated 01/15/13, revealed Resident #1 was alert and oriented x 3 (person, place, time). The resident was verbally responsive and able to make his/her needs known. Resident #1 continued to follow up with dermatologist related to lesions on the scalp; however, Resident #1 continued to refuse daily treatments by the nurses.<br><br>Review of Resident #1's Meal Intake Detail Report, revealed from 12/06/12 through 03/06/13, Resident #1 was eating partial meals or refusing to eat meals and alternatives.<br><br>Interview with Certified Nursing Assistant (CNA) #7, on 03/07/13 at 9:23 AM, revealed Resident #1 had some behaviors like refusing care and yelling at staff.<br><br>Interview with Licensed Practical Nurse (LPN) #4, on 03/07/13 at 9:28 AM, revealed she had noticed Resident #1's behaviors. Resident #1 would say things like he/she did not want something or wanted to just go to sleep. When Resident #1 had the lesions on his/her head, the resident would pick at them. Resident #1 would allow me to apply the treatment but would not allow for the bandages to be placed. The Doctor wanted the lesions bandaged so the resident would not pick at his/her scalp. LPN #4 stated Social Services was aware of Resident #1's behavior.<br><br>Interview with the Social Services Assistant Director (SSAD), on 03/07/13 1:18 PM, revealed when a resident was newly admitted the resident received an initial assessment from Social | F 279  |   |                      |  |

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| F 279   | Continued From page 13<br>Services and then the resident was evaluated quarterly and annually. The Assistant Social Services Director stated she looked at the care tracker reports, the nurses notes and interviewed the residents themselves to obtain information. The SSAD stated no nursing staff had come to her requesting a psychiatric evaluation. The SSAD stated she never saw his behaviors as behavior, but as his/her personality which was a very aggressive person. The SSAD stated when the resident refused care he/she had a reason. Resident #1 did not like to be told what to do. He/she had to decide when he/she would take a shower. The SSAD further stated he/she should have developed a refusal of care care plan. The SSAD stated she was the one who initiated the behavior care plans.<br><br>2. Observation of the lunch meal service, on 03/06/13 at 1:00 PM, revealed Resident #15 was delivered a meal tray with one (1) two handled cup with a lid and three (3) different types of liquids. A glass of water was in a regular cup with no straw, an orange liquid was in a regular clear glass with no straw, and the health shake was opened by a staff member who placed a straw in the carton. The 2 handled cup was filled with coffee, the staff member poured some of the health shake into the cup of coffee and covered it with the lid. The straw was then place through the lid and left the rest of the shake in the carton with no straw. The resident made no attempts to | F 279  |   |                      |  |

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| F 279   | Continued From page 14<br>drink the liquids that were not in a 2 handled cup.<br><br>Observation of the breakfast meal, on 03/07/13 at 8:35 AM, revealed the resident's coffee was in the 2 handled cup with a lid and straw. However, the residents milk, orange juice and cranberry juice were still in their original cartons with no straw. No other 2 handled cups were noted on the tray and the resident made no attempts to pickup the fluids not in the facility recommended sippy cup.<br><br>Observation of the lunch meal, on 03/07/13 at 12:45 PM, revealed the resident's meal tray did not have any 2 handled sippy cups with lids.<br><br>Review of Resident #15's tray card and Dietary Resident Profile Report, not dated, revealed the resident was to receive a sippy cup. Review of the facility's comprehensive plan of care for Resident #15 revealed the resident was at risk for alteration in nutrition and insufficient fluid intake. However, the facility listed an approach to use special equipment to help the resident be more independent, but did not list what equipment was to be used. Review of the Certified Nursing Assistant's (CNA) plan of care revealed the resident did not have any type of assisted devices listed to aide the resident in eating independently.<br><br>Review of the clinical record for Resident #15 revealed the facility admitted the resident, on 12/05/07, with the following diagnoses: Alzheimers, Congestive Heart Failure, Hypertension, Depression, Dementia, and Anxiety. Review of Resident #15's Quarterly RAI, dated 12/17/12 revealed the facility assessed the resident as needing extensive assistance with eating and a mechanically altered diet. Review of | F 279  |   |  |

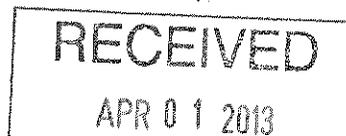
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| F 279   | Continued From page 15<br>the Quarterly Nutrition Assessment, dated 12/17/12, revealed the resident's self feeding ability required a sippy cup, scoop plate, and assistance setting up the meal tray resulting in the resident having the ability to feed themselves. The facility assessed the resident as requiring a two (2) handled cup with a lid due to an inability to drink out of a regular cup and a resident change form was submitted to the dietary department on 06/05/12.<br><br>Interview with CNA #2, on 03/07/13 at 1:00 PM, revealed the 2 handled cup was used to prevent the resident from spilling their drinks. The CNA revealed the resident was assessed as having tremors to their arms and was having difficulty using a regular cup.<br><br>Interview with Licensed Practical Nurse (LPN) #1, on 03/07/13 at 2:15 PM, revealed the resident did require the use of a sippy cup to ensure proper nutrition and hydration. The LPN revealed she was not aware the care plan did not direct what type of adaptive equipment to use. The LPN revealed a potential for the resident to not receive the cup if not specified and individualized to that resident's assessed need. The LPN revealed it was the nurses responsibility to ensure the CNA care plans were developed, correct, and updated as necessary to ensure the needs of the resident were being met.<br><br>Interview with the Unit Manager, on 03/07/13 at 2:30 PM, revealed the resident's adaptive equipment should be listed on the care plan and identified by name as to which device to use. The Unit Manager revealed a potential for the staff to not know what items were needed to | F 279  |   |                      |  |



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| F 279   | Continued From page 16<br>ensure the resident had as much independence as possible. The Unit Manager revealed she was new to the facility and had not identified a problem with care plans and was not monitoring to ensure the comprehensive plan of care specified the resident's individual needs.<br><br>Interview with the Minimum Data Set (MDS) Coordinator, on 03/07/13 at 3:15 PM, revealed Resident #15's old care plan did list which adaptive equipment was assessed as a resident need. However, during development of the 09/18/12 comprehensive plan of care, the items were removed and replaced with a general statement. The MDS Coordinator revealed she did not know why it was removed but said the information should be on the care plan to ensure the resident received the appropriate items.                                 | F 279  |   |  |
| F 280<br>SS=D   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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 | F 280  | F-280<br>1. Resident #1 weight was evaluated and was placed on the Nutritionally at Risk (NAR) program. Resident, Family and MD are aware of status. This was completed on 3/5/13 by Unit Manager and Assistant Dietary Manager. Registered Dietitian evaluated and assessed.<br>2. An audit of all resident weight changes was conducted on 3/5/13 by DON to ensure significant weight changes were addressed and residents were added to Nutritionally at Risk (NAR) program. | Completion by:                               |

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| F 280   | Continued From page 17 each assessment.<br><br>This REQUIREMENT is not met as evidenced by.<br>Based on interview, record review and policy review, it was determined the facility failed to revise a weight loss plan of care for one (1) of twenty-four (24) residents and three (3) un-sampled residents, Resident #1 in regards to a fourteen (14) percent weight loss in three (3) months.<br><br>The findings include:<br><br>No policy could be provided on revising a care plan; however, the facility utilized the MDS 3.0 as a reference.<br><br>Review of the MDS 3.0 Manual, Chapter 4, Section 4-6, page 4-8, revealed facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions. Section 4-7, page 4-8, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.<br><br>Review of Resident #1's clinical record, revealed the facility admitted the resident on 05/19/11 with | F 280  | Only resident #1 had a significant weight change that was not physician prescribed. Resident #1 was placed on NAR 03/05/2013.<br>MDS Staff were re-educated on reporting all weight changes addressed in MDS record, to Dietician, DON, ADON, and Unit Managers. This occurred 03/28/2013.<br>MDS Staff will give DON the Casper Report to review quarterly.<br>3. All licensed and non-licensed staff will be re-educated on documenting of meal consumption. This will include alternative meals, meal replacements and additional portions of meals. This will be presented by DON, ADON, Staff Development, Unit Managers and House Supervisor beginning 4/1/13. Nurses will complete a post-test after the education to evaluate understanding. Tests will be reviewed by DON, ADON and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed and non-licensed staff will be educated during orientation by the Staff Development Coordinator. Licensed nursing staff will be re-educated on the proper way to dispense meal supplements such as Ensure. This education will include how to properly document the consumption, initiating the supplement on the Care Plan and providing dietary department with appropriate paperwork to ensure availability of supplement. | Completion by :<br>04/19/2013                |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185180 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>03/07/2013 |
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| F 280   | Continued From page 18<br>diagnoses of Rehab Services, Congestive Heart Failure, Hypertension, Mental Disorder, Ischemic Heart Disease, Aortic Coronary Bypass, Cardiac Pacemaker, Late Effects Hemiplegia, and Hyperlipidemia.<br><br>Review of Resident #1's weights, revealed on December 2012 Resident #1 weighed 212 pounds, on January 2013 Resident #1 weighed 191.04 pounds and on February 2013 Resident #1 weighed 180 pounds.<br><br>Review of Resident #1's recent Quarterly MDS, dated 01/10/13, revealed Resident #1 had a BIM score of 13, which meant the Resident was interviewable. Further review of the Quarterly MDS, revealed Resident #1 was triggered for a weight loss that was not a physician prescribed weight loss regimen.<br><br>Review of Resident #1's Meal Intake Detail Report, revealed from dates 12/06/12 through 02/28/13 Resident #1 refused twenty-one (21) meals, though the facility offered alternatives no one identified the causal factor, risks, or the need to revise the care plan for refusals of the meals.<br><br>Review of the care plan revealed the facility had care planned Resident #1 for a significant weight loss, although the NAR program had been discontinued on 07/17/12. No supplements were noted on the care plan. Record review revealed monthly weights were to occur, not weekly weights as stated in the NAR program.<br><br>Interview with Certified Nursing Assistant (CNA) #7, on 03/07/13 at 9:23 AM, revealed Resident #1 used to eat in the green dining room. Resident #1 | F 280  | This will be presented by DON, ADON, Staff Development, Unit Managers and House Supervisor beginning 04/01/2013. Nurses will complete a post-test after the education to evaluate understanding. Tested will be reviewed by DON, ADON, and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator. Licensed Nurse's will be re-educated on the facility policy regarding change of condition. This will include notification to families and physicians when a change is noted. This will be presented by DON, ADON, Staff Development, Unit Managers and House supervisor beginning 04/01/2013. Nurses will complete a post-test after the education to evaluate understanding. Tests will be reviewed by DON, ADON, and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator. A specific employee will be scheduled weekly to obtain weights. Their job function will be to obtain weekly and monthly weights and document in Caretracker. They will also document weights in the Unit Manager's weight log. The Unit Manager will be responsible for ensuring weights are obtained in a timely manner. The Dietitian, Assistant Dietary Director and Dietary Director were educated on the location of resident weight information on 3/28/13 by Unit Managers and DON. | Completion by: 04/09/2013                    |

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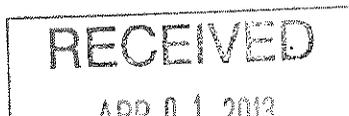
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| F 280   | Continued From page 19<br>would yell and say that he/she did not want to eat the food. Resident #1's family had brought some snacks from home for the Resident to eat. CNA #7 stated she felt Resident #1 had a weight loss and informed the nurse of this.<br><br>Interview with Licensed Practical Nurse (LPN) #4, on 03/07/13 9:28 AM, revealed she had noticed a weight loss in Resident #1. LPN #4 stated that she had been administering Med Plus to Resident #1 and at times gave him/her Ensure, though there was not an order for the Ensures. LPN #4 stated she had noted Resident #1's weight loss a few months ago and the resident stated he/she did not have an appetite and felt weak. LPN #4 stated when she gets an order from the doctor the order is transcribed onto the Care Plan. LPN #4 stated she did not think to investigate the reason behind why Resident #1 was getting smaller. LPN #4 stated she was responsible for the care provided to Resident #1 and she should have informed the doctor of the changes in Resident #1's status, then the care plan would have been updated with the care needed for Resident #1.<br><br>Interview with the Dietician, on 03/07/13 10:01 AM, revealed she was trained by the old Dietician for the months of December, January and February. The Dietician did not remember Resident #1 being someone they followed for (NAR) Nutritionally At Risk. The Dietician stated that Resident #1 was probably not on the NAR program.<br><br>Interview with the Dietary Manager, on 03/07/13 2:37 PM, revealed she was not aware there was a book of weights at the nurses station. She | F 280  | Dietary Manager and Assistant Dietary Manager will be responsible for informing Unit Manager's when a re-weight is needed. This will be effective 4/1/13.<br>4. An audit of resident weights and dietary care plans will be done each quarter with the quarterly MDS and annually with the annual MDS to ensure Dietary Care Plans are current. The Dietary Manager, Assistant Dietary Manager or MDS staff will review resident weights quarterly and annually. Unit Manager's and ADON will review monthly weights to ensure no significant weight changes have occurred. Weekly weights will be monitored in the Nutritionally at Risk program (NAR). All audit findings will be reported to the QA committee no less than quarterly for one year. |                      |  |

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04/19/2013



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| F 280   | Continued From page 20<br>always looked at the Care Tracker for documentation. The Dietary Manager remembered asking the staff for a weight and no one went to get one from Resident #1 while the dietician was present. The Dietary Manager stated she knew Resident #1 had a weight loss but needed a another weight to be obtained to prove the weight loss. The Dietary Manager stated her and the Dietary Assistant worked together, they both attend the NAR program, but the Assistant Dietary Manager attended the care plan meetings. The Dietary Manager stated the care plan should have been updated to reflect the weight that was lost at that time. She stated Resident #1 should have been on the NAR program as well. The Dietary Manager stated if Resident #1 would have continued to lose weight it could have caused Resident #1 harm. The Dietician stated she was ultimately responsible to follow up with staff to ensure there was a re-weight obtained. | F 280  |   |                               |  |
| F 325<br>SS=D   | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,  | F 325  | F-325<br>1. Resident #1 weight was evaluated and was placed on the Nutritionally at Risk (NAR) program. Resident, Family and MD are aware of status. This was completed on 3/5/13 by Unit Manager and Assistant Dietary Manager. Registered Dietitian evaluated and assessed Resident #1. | Completion by :<br>04/19/2013 |  |

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| F 325   | Continued From page 21<br>unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br><del>This REQUIREMENT is not met as evidenced by:</del><br>Based on observation, interview, record review and policy review, it was determined the facility failed to provide nutritional services for one (1) of twenty-four (24) sampled residents and three (3) unsampled residents, Resident #1 regarding an unexplained weight loss of nineteen (19) % in a five month period.<br><br>The findings include:<br><br>No policy could be provided on the monitoring of weights; however, the facility provided a policy on Nutrition and Clinical care, dated 2006, which revealed NAR residents were weighed on a weekly basis. Weekly weights were recorded on the individuals NAR worksheet and in the residents chart. The NAR committee met weekly to monitor progress toward goals. The committee consisted of all interdisciplinary care plan team members. The Registered Dietician attended a minimum of one meeting monthly. Each resident considered nutritionally at risk was documented on the medical record, by the registered dietician, a minimum of once a month, as time allowed.<br><br>Review of Resident #1's clinical record revealed the facility admitted the resident on 05/19/11 with diagnoses of Rehab Services, Congestive Heart | F 325  | 2. An audit of all resident weight changes was conducted on 3/5/13 by DON, ADON, Unit Manager's and MDS staff to ensure significant weight changes were addressed and residents were added to Nutritionally at Risk (NAR) program. Only Resident #1 had a significant weight change that was not physician prescribed. Resident #1 was placed on NAR 3/5/13.<br><br>3. MDS staff was educated on reporting all weight changes addressed in MDS record, to Dietitian, DON, ADON and Unit Managers. This occurred 3/28/13. MDS staff will report all weight loss not prescribed by a physician, monthly for no less than one year. Findings will be reported in QA committee meeting. The results of these reviews will be used to determine need for re-education. MDS staff will give DON the Casper report to review quarterly.<br>All licensed and non-licensed staff will be re-educated on documenting of meal consumption. This will include alternative meals, meal replacements and additional portions of meals. This will be presented by DON, ADON, Staff Development, Unit Managers or House Supervisor beginning 4/1/13 to be completed by 4/18/13. Staff will complete a post-test after the education to evaluate understanding. Tests will be reviewed by DON, ADON and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed and non-licensed staff will be educated during orientation by the |  |

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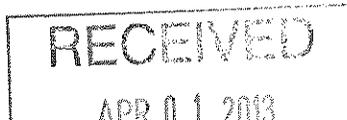
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| F 325   | Continued From page 22<br>Failure, Hypertension, Mental Disorder, Ischemic Heart Disease, Aortic Coronary Bypass, Cardiac Pacemaker, Late Effect Hemiplegia, Hyperlipidemia.<br><br>Review of Resident #1's weights, revealed on October 2012 Resident #1 weighed 223 pounds, on November 2012 Resident #1 weighed 212 pounds, on December 2012 Resident #1 weighed 212 pounds, on January 2013 Resident #1 weighed 191.04 pounds and on February 2013 Resident #1 weighed 180 pounds. A total of nineteen (19) % weight loss in five (5) months.<br><br>Review of the Care Tracker, revealed only three weights were documented 10/01/12 weight was 223, 01/02/13 weight was 191.04 and 03/06/13 weight was 180.<br><br>Review of Resident #1's physician orders, dated 02/01/13, revealed Resident #1 had orders for Lasix 40 mg twice a day (water pill), Digoxin 125 mcg daily (heart medication), Coreg 12.5 mg twice a day (blood pressure), Aspirin 81 mg daily (blood thinner), Potassium 20 meq daily. Elevate legs for water build up and TED hose to prevent the fluid from pooling in the lower extremities. Review also revealed Resident #1 was given a one time immediate dose of Lasix 40 mg on 01/28/13.<br><br>Review of Resident #1's recent Quarterly MDS, dated 01/10/13, revealed Resident #1 had a BIM score of 13, which meant the Resident was interviewable. Further review of the Quarterly MDS, revealed Resident #1 was triggered for a weight loss that was not a physician prescribed weight loss regimen. | F 325  | Staff Development Coordinator. Licensed nursing staff will be re-educated on the proper way to dispense meal supplements such as Ensure. This education will include how to properly document the consumption, initiating the supplement on the Care Plan and providing dietary department with appropriate paperwork to ensure availability of supplement. This will be presented by DON, ADON, Staff Development, Unit Managers or House Supervisor beginning 4/1/13 to be completed by 4/18/13. Nurses will complete a post-test after the education to evaluate understanding. Tests will be reviewed by DON, ADON and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator. Licensed nurses will be re-educated on the facility policy regarding change of condition. This will include notification to families and physicians when a change is noted. This will be presented by DON, ADON, Staff Development, Unit Managers or House Supervisor beginning 4/1/13 to be completed by 4/18/13. Nurses will complete a post-test after the education to evaluate understanding. Tests will be reviewed by DON, ADON and Staff Development. This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed staff will be | Completion by :<br>04/19/2013                |

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| F 325   | Continued From page 23<br><br>Review of Resident #1's Meal Intake Detail Report, revealed from dates 12/06/12 through 02/28/13 Resident #1 refused twenty-one (21) meals, although the facility offered alternatives no one identified the accumulated refusals of the meals by Resident #1   | F 325  | Dietary Manager and Assistant Dietary Manager will be responsible for informing Unit Manager's when a re-weight is needed. This will be effective 4/1/13. A specific employee will be scheduled weekly to obtain weights. Their job function will be to obtain weekly and monthly weights and document in Caretracker.  |  |
|   | Observation of Resident #1, on 03/06/13 at 8:36 AM, revealed Resident #1 had eaten 100% of his/her breakfast.<br><br>Interview with Resident #1, on 03/06/13 at 5:07 PM, revealed Resident #1 knew he/she had lost some weight and was not concerned because he/she felt like he/she could loose a little weight. Resident #1 stated he/she felt the food was fifty (50)% ok. Resident #1 stated he/she ate three meals a day at about sixty (60) %.<br><br>Interview with Certified Nursing Assistant (CNA) #7, on 03/07/13 at 9:23 AM, revealed Resident #1 used to eat in the green dining room. Resident #1 would yell and say that he/she did not want to eat the food. Resident #1's family had brought snacks from home for the Resident to eat. CNA #7 stated she felt Resident #1 had a weight loss and informed the nurse of this.<br><br>Interview with Licensed Practical Nurse (LPN) #4, on 03/07/13 at 9:28 AM, revealed she had noticed a weight loss in Resident #1. LPN #4 stated that she had been administering Med plus to Resident #1 and at times gave him/her Ensure, although there was not an order for the Ensures. LPN #4 stated she had noted Resident #1's weight loss a few months ago and Resident #1 stated he/she did not have an appetite and felt weak. LPN #4 |  | They will also document weights in the Unit Manager's weight log. The Unit Manager will be responsible for ensuring weights are obtained in a timely manner. The Dietitian, Assistant Dietary Director and Dietary Director were educated on the location of resident weights on 3/28/13 by Unit Managers.<br><br>4. A monthly audit of all resident's weights will be conducted by utilizing the weights change report. The report will be audited by the 15 <sup>th</sup> of each month to ensure all monthly weights have been obtained. The audit will be conducted by DON, ADON, MDS staff, Staff Development or Unit Managers. 100% of all resident's weights will be audited for 3 months, then 50% of residents for 1 quarter and then 25% for 2 quarters. The findings will be reported to the QA committee no less than quarterly for one year. | Completion<br>by :<br>04/19/2013             |



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| F 325   | Continued From page 24<br>stated she did not think to investigate the reason behind why Resident #1 was getting smaller. LPN #4 stated she was responsible for the care provided to Resident #1 and she should have informed the doctor of the changes in Resident #1's status.<br><br>Review of the Quarterly Nutrition Assessment, conducted by the Dietician, on 10/08/12, revealed the resident's weight had increased, there was a prior weight loss, and a weight gain was desired. The resident is currently back to his/her usual body weight recommended (UBWR). Good oral intake of seventy-two (72)%. Labs noted Hgb A1C (Diabetic test) elevated. No sign of changes in resident overall. Recommend changing the diet to a controlled carb diet to help control blood sugar levels. Continue the No Added Salt restriction.<br><br>Review of the Quarterly Nutrition Assessment conducted by the Dietician, on 01/02/13, revealed Resident #1's weight was stable with no signs of changes. Stable with good intakes at seventy-eight (78)%. Labs noted. Meeting goals. No changes to plan of care at this time.<br><br>Interview with the Dietician, on 03/07/13 at 10:01 AM, revealed she was trained by the old Dietician for the months of December, January and February. The Dietician did not remember Resident #1 being someone they followed for care. The Dietician stated that Resident #1 was probably not on the NAR program. The Dietician thought the diet change in November could have caused an intentional weight loss; however, upon further review the Dietician stated the diet change was not a significant diet change. She would not | F 325  |   |  |

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| F 325   | Continued From page 25<br>have expected him to lose that much weight on the diet. The Dietician stated if the weight was brought to her attention she would have definitely looked at his intake. She was told of the significant weight loss on 03/05/13 when the Director of Nursing was asked to correct her roster matrix to indicate the weight loss of Resident #1.  | F 325  |   |                      |  |
|   | Review of the Nutrition Services Progress Note, dated 03/05/13, revealed Resident #1 had a significant weight loss of 5.7% in one (1) month and fifteen (15) % weight loss in two (2) months. Average intake was 63%. The resident's Body Mass Index was 27.4 which was an overweight status. The resident's intake was estimated at 2045 cal/day, and 82-98 grams of protein a day. It was recommended the facility monitor the resident in the NAR program and provide 90 ml of Med Plus three times a day to prevent further weight loss. Continue to follow on the NAR program.<br><br>Further interview with the Dietician, on 03/07/13 at 10:01 AM, revealed if the weight loss was brought to her attention she would have definitely looked at Resident #1's intake. The Dietician stated when she looked at a resident she assessed changes in the medications, labs, oral intake or tube feeding, chewing or swallowing issues, and behaviors like confusion. Once she looked at the intakes and noticed something not typical, then she looked further. The Dietician stated someone should have documented the weight loss. She stated she would have started a significant weight loss assessment based on the possible reasons of lack of intake, confusion, and they look at supplements and fortified foods. The |  |   |                      |  |



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| F 325   | Continued From page 26<br>Dietician would write this in the chart and pass on to the nurse the recommendation to obtain orders from the doctor. The Dietician noted Resident #1's weight was in the two-twenty's (220) upon admission. The Dietician felt the previous Dietician was really on top of the weights and that she had charted quarterly. Sometimes the Dietician may do an assessment of the Resident first and then ask for a weight. She stated technically, looking back three months, the previous Dietician did what was appropriate.<br><br>Interview with the Dietary Manager, on 03/07/13 2:37 PM, revealed she was not aware there was a book of weights at the nurses station. She always looked at the Care Tracker for documentation. The Dietary Manager remembered asking the staff for a weight and the staff did not obtain a weight for Resident #1 while the dietician was present in January. The Dietary Manager stated she knew Resident #1 had a weight loss but needed another weight to be obtained to prove the weight loss. The Dietary Manager stated her and the Dietary Assistant worked together, they both attend the NAR program. She stated Resident #1 should have been on the NAR program as well. The Dietary Manager stated if Resident #1 would have continued to lose weight it could have caused Resident #1 harm. The Dietary Manager stated she was ultimately responsible for follow up with staff to ensure there was a re-weight obtained.<br><br>Interview with Resident #1's Physician, on 03/07/13 at 2:02 PM, revealed he was not aware of a significant weight loss. The Physician stated Lasix could cause weight loss, but not that much weight. The Physician stated Resident #1 needed | F 325  |   |                      |  |

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| F 325   | Continued From page 27<br>to stay on Lasix and he/she was extremely contrary to his/her medications. The Physician stated it did not surprise him there was a weight loss with Resident #1 because he/she complained about everything. The Physician stated a continued weight lose could be harmful to his health.   | F 325  |   |                               |  |
| F 365<br>SS=D   | Interview with the Director of Nursing (DON), on 03/07/13 at 4:03 PM, revealed the Unit Managers were keeping the weight logs. There were not many weights logged in the Care Tracker. There had been a lack of communication regarding documentation of the weights. The DON stated it was her expectation for the CNA staff to document and alert the nursing staff of the weight change. The CNA's were taking the weights and documenting them and the Unit Managers were supposed to be monitoring the weights. This was the system. The DON stated that she noticed the resident refusing meals, but the resident had a lot of food in his/her room and he/she did eat a lot. When asked who was responsible to ensure the residents were taken care of appropriately, the DON stated it was one person that failed and that was why they had a new Unit Manager.<br>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS<br><br>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined the facility failed to | F 365  | F-365<br>Resident #5 and #15 had finger foods added to CNA and nursing Care Plans on 3/18/13. Resident #15 adaptive equipment, consisting of 2-handled cups with lids and scoop plate for meals, was specified on Care Plan on 3/18/13 by Unit Man- | Completion by :<br>04/19/2013 |  |

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| F 365   | Continued From page 28<br>provide two (2) of the twenty-four (24) sampled residents and three (3) unsampled residents (Resident #5 and #15) with food that was in a form to meet the individual needs of the resident.<br><br>The findings include:<br><br>The facility did not provide a policy for therapeutic diets.  | F 365  | 2. An audit of all resident's with finger foods ordered was completed on 3/7/13 by DON to ensure proper meals were being served, correct information was found on meal card and the foods present were able to be eaten with the hands only. The foods found were appropriate for eating with the hands. Residents were feeding themselves with minimal assistance.<br>3. Registered Dietitian will re-educate dietary staff regarding substitutions for finger foods and appropriate adaptive equipment to include individual beverage containers for each drink. The education will begin 4/2/13 and Staff Development coordinator will be present. Staff Development will then educate new dietary employees during orientation.<br>Licensed and non-licensed nursing staff will have a food tray simulation to re-educate on reading tray cards correctly. They will have a quiz to utilize for the process to determine that the information is understood. This will be presented starting 4/15/13 by DON, ADON, Staff Development Coordinator, Unit Managers, Dietary Manager or House Supervisor. This will be included in annual competency check-offs.<br><br>4. The DON, ADON, Unit Managers, Social Services or House Supervisor will observe a minimum of 4 people in each dining location, 2 meals per day for a minimum of 5 days per week for 4 weeks, to ensure the tray cards match the resident meals they should be receiving. | Completion by :<br>04/19/2013                |
|   | 1. Observation of the lunch meal in the East dining room, on 03/06/13 at 12:50 PM, revealed Resident #5 attempting to eat one-half of a baked potato with his/her fingers. The potato, which had not been cut into bite size pieces, had butter and sour cream applied by a staff prior to the resident picking it up with his/her fingers. Further observation of Resident #5 revealed a staff offered assistance with eating to the resident at 1:10 PM allowing twenty (20) minutes to elapse while the butter and sour cream was observed dripping down the resident's arm.<br><br>Review of Resident #5's clinical record revealed an Occupational Therapy Summary note, dated 05/11/12, that revealed Resident #5's hand function was within normal limits. The facility assessed the resident as having a cognition score of 2 on the Minimum Data Set (MDS), dated 12/11/12, which indicated a severe deficit in cognition. Review of the record's current physician order sheet revealed a concentrated carbohydrate diet with finger foods was ordered.<br><br>2. Observation of lunch in the East dining room, on 03/06/13 at 1:00 PM, revealed Resident #15's lunch meal consisted of fried chicken, green beans, and a baked potato. A staff member |  |  |  |

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| F 365   | Continued From page 29<br>partially cut the potato leaving the skin intact and applied butter and sour cream to the potato. The resident picked up the potato resulting in chunks of the potato, butter and sour cream falling into the residents lap, on the floor, and back on the plate. The resident continued to try and eat the baked potato biting into the skin and pushing some of it into his/her mouth.  | F 365  | They will continue with 2 people in each dining location, 2 meals per day no less than 5 days per week for 4 weeks; then they will observe 2 people, 2 meals per day, twice weekly for one month; then 2 people in each location, 1 meal per day, twice a week for 9 months. Results will be used to determine the need for re-education. The results will be reported to QA committee no less than quarterly for one year. |                               |  |
|   | <p>Review of Resident #15's clinical record revealed the facility assessed the resident using the Quarterly MDS, dated 12/17/12, as needing extensive assistance of one staff for eating and to require a mechanically altered diet. Review of the Dietary Resident Profile Report, not dated, revealed the resident was assessed as needing finger foods.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 03/07/13 at 12:55 PM, revealed Resident #15 and Resident #5 were to have finger foods to help increase their independence with eating.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/07/13 at 2:15 PM, revealed Resident #5 and Resident #15 were supposed to have finger foods. The LPN revealed it was a potential concern for the residents to feel belittled by getting food on themselves, not being able to eat and not getting the proper nutrition if they were not served the appropriate foods for their dietary needs. LPN #1 revealed she would not consider a baked potato a finger food.</p> <p>Interview with the East Unit Manager, on 03/07/13 at 2:30 PM, revealed a baked potato would not be considered a finger food. The Unit Manager revealed finger foods would be ordered to help</p> |  |   | Completion by :<br>04/19/2013 |  |

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| F 365   | <p>Continued From page 30</p> <p>increase the resident's independence and ability to feed themselves. The Unit Manager revealed she was not monitoring to ensure staff were reading the tray cards to ensure residents were receiving the appropriate types of food.</p> <p>Interview with the Registered Dietician (RD), on 03/07/13 at 2:45 PM, revealed finger foods would be recommended when a resident was having difficulty with eating but was not ready for restorative dining. The RD revealed not providing the appropriate foods could result in the resident not eating and not feeling good about themselves and their ability to eat.</p> <p>Interview with the Assistant Dietary Manager, on 03/07/13 at 2:50 PM, revealed a finger food substitute for a baked potato could be french fries, potato wedges, later tots or hash browns.</p> <p>Review of the dietary spread sheet for 03/06/12 revealed potato wedges were listed as the finger food selection.</p> <p>Continued interview with the Assistant Dietary Manager revealed the cook should have prepared potato wedges, which were in stock in the facility, for those residents needing finger foods. The Assistant Dietary Manager revealed the cook was responsible to ensure all options were made available to the residents and she did not know why or how it was missed during the tray line.</p> <p>Interview with the Director of Nursing (DON), on 03/07/13 at 3:50 PM, revealed she had noticed a problem before with residents not receiving finger foods and did address this with the dietary department; but had not noticed any more</p> | F 365  |   |                      |  |

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| F 365   | Continued From page 31 concerns.   | F 365  | F-369  |  |
| F 369<br>SS=D   | 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS<br><br>The facility must provide special eating equipment and utensils for residents who need them.  | F 369  | 1. Resident #15's adaptive equipment, consisting of 2-handled cups with lids and scoop plate for meals, was specified on Care Plan on 3/18/13 by Unit Manager.<br>2. A Care Plan audit of all resident's with adaptive equipment was conducted to ensure that specific adaptive equipment  |  |
|   | This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of the facility's Dietary Resident Profile Report, it was determined the facility failed to provide one (1) of the twenty-four (24) sampled residents and three (3) unsampled residents (Resident #15) with an adaptive drinking device assessed as a need by the facility's nursing staff.<br><br>The findings include:<br><br>Interview with the Director of Nursing (DON), on 03/07/13 at 2:45 PM, revealed the facility did not have a policy or procedure for residents' adaptive equipment for dietary needs.<br><br>Review of the clinical record for Resident #15 revealed the facility admitted the resident on 12/05/07 with the following diagnoses: Alzheimers; Congestive Heart Failure; Hypertension; Depression; Dementia; and Anxiety. Review of Resident #15's Quarterly MDS, dated 12/17/12, revealed the facility assessed the resident as needing extensive assistance with eating and a mechanically altered diet. Review of the Quarterly Nutrition Assessment, dated 12/17/12, revealed the resident's self feeding ability required a sippy cup, scoop plate, and assistance setting up the meal |  | <del>was listed on Care Plan. All Care Plans were updated by DON and MDS staff to include the specific adaptive equipment and completed by 3/18/13.</del><br>3. MDS staff, Dietary Manager and Assistant Dietary Manager, received education on adding specific adaptive equipment to Care Plans on 3/7/13 by DON and ADON. Dietary staff are being re-educated on providing a different sippy cup for each beverage on the meal tray; this will include soup in a 2-handled cup with a lid as well. In-service will begin 4/1/13 and be presented by Dietary Manager and Assistant Dietary Manager. Staff Development Coordinator will be responsible for educating new dietary employees during orientation. Licensed nursing staff will be educated on writing specific adaptive equipment on Care Plans. Both licensed and non-licensed staff will be re-educated to ensure proper adaptive equipment is in place when passing trays. This will be presented by DON, ADON, Staff Development, Unit Managers or House Supervisor beginning 4/1/13. Staff will complete a post-test after the education to evaluate understanding. Tests will be reviewed by | Completion by:<br>04/19/2013                 |

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| F 369   | Continued From page 32<br>tray. The resident was then able to feed themselves. The facility assessed the resident as requiring a two (2) handled cup with a lid due to an inability to drink out of a regular cup and a resident change form was submitted to the Dietary Department on 06/05/12. Review of the Dietary Resident Profile Report, not dated, revealed the resident was to use a sippy cup at meals.   | F 369  | This education will be repeated quarterly for 3 quarters then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator.<br>A Care Plan audit will be completed by MDS staff, Assistant Dietary Manager or Dietary Manager with every Quarterly and Annual MDS assessment and during Care Plan meetings quarterly, for no less than a year. Findings will be reported to QA committee no less than quarterly for one year.<br><br>4. The DON, ADON, Unit Managers or Unit Secretary's will observe a minimum of 5 meals per week for 3 months to ensure proper adaptive equipment is in place on meal trays. Observation of meals will continue with 3 meals per week for six months and then 1 meal per week for 3 months. The findings will be reported to the QA committee no less than quarterly for one year. |  |
|   | Observation of the lunch meal service in the East dining room, on 03/06/13 at 1:00 PM, revealed Resident #15's lunch tray with a regular clear cup filled with water and no straw, a regular clear cup with an orange liquid and no straw, and an opened health shake carton with a straw. The nursing staff was observed filling the 2 handled cup with coffee, pour some of the health shake into the cup, cover it with a lid and remove the straw from the health shake and place in the 2 handled cup. The resident picked up the cup utilizing the handles; but did not attempt to pick up the other beverages on the tray, which were not in the specialized adaptive cup.<br><br>Observation of breakfast, on 03/07/13 at 8:35 AM, revealed the resident's tray with coffee in the 2 handled sippy cup, a carton of milk opened with no straw, a carton of orange juice opened with no straw, and a carton of cranberry juice opened with no straw. No attempts were made by the resident to pick up any fluids not in the 2 handled cup.<br><br>Observation of lunch, on 03/07/13 at 12:54 PM, revealed the resident had coffee in a regular coffee cup, soup in a regular coffee cup, a yellow liquid in a regular clear cup with a straw, and a |  |  | Completion by :<br>04/19/2013                |



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| F 369   | Continued From page 33<br>carton of the facility's healthshake opened and no straw. The Resident was observed trying to drink out of the coffee cups using both hands and the cup slipping and dangling down in the direction opposite of the handle. No sippy cup was observed in use or on the tray.  | F 369  |   |  |
|   | <p>Interview with Certified Nursing Assistant (CNA) #2, on 03/07/13 at 1:00 PM, revealed the resident was not sent a 2 handled cup for lunch and the resident did appear to be having difficulty using the regular coffee cup. The CNA revealed the resident started using the cup due to tremors in the residents arms and frequent spillage. The CNA revealed the staff was supposed to look at the tray cards and ensure all residents had the adaptive devices needed for dining. The CNA revealed dietary only sent one adaptive cup per tray so staff were rinsing out the resident's cup and reusing it for a different liquid which limited beverage options.</p> <p>Interview with CNA #1, on 03/07/13 at 12:55 PM, revealed all liquids should be in an adaptive drinking cup; but dietary only sent one cup for the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/07/13 at 2:15 PM, revealed the resident drinks well with a straw; but required both handles to control the cup.</p> <p>Interview with Speech Therapy, on 03/07/13 at 2:40 PM, revealed 2 handled sippy cups were used when a resident had difficulty controlling a cup and could result in a dignity issue if not used and residents are spilling things on themselves.</p> |  |   |  |

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| F 369   | Continued From page 34<br>Interview with the Registered Dietician, on 03/07/13 at 2:45 PM, revealed each beverage should have had its own adaptive cup, meaning, if the resident had four (4) different beverages for a meal then there should be four (4) cups, one for each beverage.<br><br>Interview with the Assistant Dietary Manager, on 03/07/13 at 4:05 PM, revealed the dietary aides set up the trays and place the adaptive cups on each tray. The Assistant Dietary Manager revealed the kitchen had always just sent one cup and did train the dietary aides to only provide one cup. However, The Assistant Dietary Manager revealed other types of specialized cups provided by the facility were sent to other residents as one cup for each type of beverage. The Assistant Dietary Manager could not provide an explanation as to why the 2 handled cups were not handled in the same fashion, just that the facility had always done it that way. | F 369  |   |                      |  |
| F 441<br>SS=D   | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and  | F 441  |   |                      |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185180 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>03/07/2013 |
|---|---|--|---|--|
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| F 441   | Continued From page 35 to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br><br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, it was determined the facility | F 441  | F-441<br>1. LPN #1 and LPN #2 were educated and observed on 3/6/13 regarding proper technique for conducting sanitary skin assessments and treatments. Re-education was conducted by DON and Unit Managers. An understanding was met by performing tasks as policy states.<br><br>Resident #3's room was deep cleaned on 3/7/13 to ensure furniture was free from germs.<br><br>2. Licensed and non-licensed staff have been observed on the following dates: 3/11/13-3/15/13, 3/18/13-3/22/13 and 3/25/13-3/29/13 to ensure they are following proper infection control policies. Observation was during skin assessments, treatment changes, bathing, toileting and feeding. Observation was conducted by DON, ADON, Unit Managers, QA nurse, Unit Secretary and Staff Development Coordinator.<br><br>3. Staff education for licensed and non-licensed nursing staff will be conducted starting 4/1/13 regarding glove use, PPE and hand washing. Scenarios will be created to ensure staff is fully aware of when to remove gloves and change how to properly wash hands and the use and removal of PPE. Re-education will be conducted by DON, ADON, Staff Development Coordinator, Scheduling Coordinator, Unit Managers or House Supervisor, quarterly for 3 quarters and annually with competency check-offs. | Completion by :<br>04/19/2013                |

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| F 441   | Continued From page 36<br>failed to ensure the staff changed their gloves and washed their hands during skin assessments for two (2) of twenty-four (24) sampled residents and three (3) unsampled residents. (Resident #3 and #8)<br><br>The findings include:<br><br>Review of the facility's policy regarding Hand Hygiene, dated 08/01/12, revealed Personnel were to wash their hands before and after direct resident contact (indicated by acceptable professional practice) and hand hygiene must be performed when moving from a contaminated body site to a clean body site during resident care.<br><br>Observation, on 03/06/13 at 11:25 AM, revealed a skin assessment performed for Resident #3 by Licensed Practical Nurse (LPN) #1 and LPN #2. During that skin assessment LPN #1 did not wash or sanitize her hands prior to beginning the assessment and donning gloves. LPN #1 applied Mary's Magic Butt Cream to the skin surrounding the resident's anal area with her gloved hand, briefly held Resident #3's left hand, touched other areas of the resident's bare skin, re-dressed the resident, and touched the drawer handles of Resident #3's dresser, without first removing her soiled gloves and washing her hands. During the same skin assessment, LPN #2 touched Resident #3's vulva and labial folds and did not remove her gloves, wash her hands, and re-glove before continuing the assessment touching areas of Resident #3's legs, feet, and toes.<br><br>Review of the clinical record for Resident #3 revealed the facility admitted the resident on | F 441  | Staff will perform specific tasks and a check off list will be utilized to ensure staff understanding of procedures.<br><br>4. DON, ADON, Unit Managers or House Supervisor will observe a minimum of 5 staff per week for 3 months, then 5 staff per month for 3 quarters to ensure proper hand washing, hand washing with treatments and skin assessments, glove donning and doffing and correct usage of PPE. Results of these observations will be used to determine need of re-education. Results will be reported to QA committee for no less than 3 quarters for one year. |  |

Completion  
by  
04/19/2013

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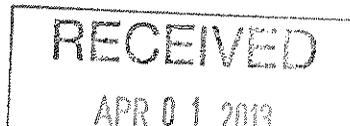
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| F 441   | Continued From page 37<br>12/30/11 with diagnoses of Vascular Dementia, Pyelonephritis, Eosinophilic Colitis, a history of Trans-Ischemic Attacks (TIAs), Diaphragmatic Hernia, Osteoporosis, Pernicious Anemia and a history of Urinary Tract Infections (UTIs). Resident #3 triggered for pressure ulcers through the Care Area Assessment (CAA) within a Significant Change Minimum Data Set (MDS), dated 11/19/12; and weekly skin assessments were care planned for Resident #3.<br><br>Interview with LPN #2, on 03/06/13 at 3:00 PM, revealed she should have removed her gloves after touching Resident #3's perineal area, washed her hands and donned a clean pair of gloves before touching Resident #3's legs, feet and toes. LPN #2 stated the potential for the spread of infection existed when glove changes and hand washing were not observed and when moving from dirty to clean areas of the body. LPN #2 was unsure of exactly when she received infection control in-service education; but thought it had occurred in the past ninety (90) days.<br><br>Interview with LPN #1, on 03/06/13 at 3:10 PM, revealed she should have removed her gloves and washed her hands during the skin assessment of Resident #3 because the spread of infection to Resident #3 or to other residents and staff was a potential problem. LPN #1 stated she could not remember the exact date of her last infection control in-service, but she thought it occurred about two (2) months ago.<br><br>Interview, on 03/07/13 at 10:30 AM, with the Unit Manager (UM) for the East Unit, revealed nurses should wash their hands prior to beginning a skin assessment and gloves should be removed | F 441  |   |                      |  |

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| F 441   | Continued From page 38<br>during any care procedure once gloves become soiled or potentially contaminated. The UM stated LPN #1 and LPN #2 should have removed their soiled gloves, washed their hands and donned clean gloves before continuing to assess Resident #3's skin and giving additional care.<br><br>Interview, on 03/07/13 at 12:55 PM, with the Infection Control Nurse, revealed she made daily rounds on each unit to monitor for breaks in infection control by staff and within the general environment. She stated licensed nurses received infection control in-service education upon hire, annually, and whenever it was determined additional education was needed. The Infection Control Nurse also stated an in-service on how to perform and document a skin assessment was conducted for all licensed nurses on 02/07/13.<br><br>The Infection Control Nurse further stated a skills check list was completed for each Certified Nursing Assistant (CNA) within the first ninety (90) days after hire and annually thereafter. She stated the check list covered proper hand hygiene and use of personal protective equipment including how and when to apply and remove gloves. She also stated all direct care staff should observe proper hand hygiene prior to and after giving care to a resident which included removing soiled gloves, washing hands and donning clean gloves any time gloved hands became soiled or came in contact with potentially contaminated skin or mucous membranes. | F 441  |   |                      |  |



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| NAME OF PROVIDER OR SUPPLIER<br><br>NORTH HARDIN HEALTH & REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>599 ROGERSVILLE RD.<br>RADCLIFF, KY 40160                              |  |
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| K 000   | INITIAL COMMENTS<br><br>CFR: 42 CFR 483.70(a)<br><br>BUILDING: 01<br><br>PLAN APPROVAL: 1986, 1992  | K 000  |   |  |
|   | SURVEY UNDER: 2000 Existing<br><br>FACILITY TYPE: SNF/NF<br><br>TYPE OF STRUCTURE: One (1) story, Type III (000)<br><br>SMOKE COMPARTMENTS: Eight (8) smoke compartments.<br><br>FIRE ALARM: Complete fire alarm system with smoke detectors.<br><br>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.<br><br>GENERATOR: Type II generator, Fuel source is diesel.<br><br>A standard Life Safety Code survey was conducted on 03/06/2013. 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). The census the day of the survey was one hundred thirty (130). |  |   |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE           |   | TITLE  |   | (X6) DATE                                    |
| X   |   | X  |   | X  |

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

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