

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

PRINTED: 08/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2011
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NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 08/09-11/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>An abbreviated standard survey (KY15286, KY15325, KY15668, KY15832, KY15892, KY15962, KY15990, KY16171, KY16793) was also conducted at this time. The allegations were unsubstantiated with no related deficient practice.</p>	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide care for each resident that promoted the resident's dignity and respect. Observation on 08/10/11, at 9:15 AM, revealed staff failed to knock on Resident 13's door prior to entering the resident's room, while a private conversation/interview was being conducted.</p> <p>The findings include: Review of the facility's policy titled Resident's Rights (not dated) revealed each resident would be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his</p>	F 241		

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

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F 241	Continued From page 1 personal needs. Further review of the policy revealed residents have the right to have private meetings with the appropriate long-term care facility inspectors for the Cabinet for Human Resources and may associate and communicate privately with persons of their choice. On 08/10/11, at 9:15 AM, a Quality of Life Assessment interview was conducted with Resident #13. During the private conversation, CMA #2 opened the resident's door and entered the resident's room, interrupting the conversation and without obtaining the resident's permission. CMA #2 was carrying a nasal spray, an inhaler, oral medications in a medication cup, and a cup of water in her hands. CMA #2 administered the medications to Resident #13 without acknowledgement of the private conversation/interview being conducted. Interview on 08/10/11, at 10:15 AM, with CMA #2 revealed the CMA stated she should have knocked on Resident #13's door and should have waited for a response from the resident before entering the resident's room. The CMA stated she had her hands full with the resident's medications but should have placed the medications on the medication cart, positioned at the resident's door, so she could have knocked on the resident's door. Interview on 08/10/11, at 3:00 PM, with the DON revealed staff should knock on the resident's door prior to entering the resident's room. The DON stated staff should pause and listen for the resident to respond to the knock before entering the resident's room.	F 241			
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=E	<p>Continued From page 2 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on environmental observation, interview with the Housekeeping/Maintenance Supervisor, and review of the maintenance policy and work orders, it was determined the facility failed to ensure the resident environment was as free of accident hazards as possible. Four fire extinguishers were mounted on walls near handrails on the front hallway of the facility with a bracket that could allow the fire extinguisher to be easily dislodged and fall to the floor. In addition, a nail was observed protruding from the edge of a counter in the activity room, and a door was observed with a chipped rough edge in resident room 103.</p> <p>The findings include:</p> <p>A review of the facility policy titled Equipment Maintenance (dated 12/07/09) revealed that if a hazard was found at any time the hazard would be reported to the center manager for immediate repair.</p> <p>Observations conducted during an environmental</p>	F 323			

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F 323	Continued From page 3 tour on 08/11/11, at 2:05 PM, revealed four fire extinguishers, weighing 15 pounds, mounted on the walls of facility hallways. Further observation revealed the fire extinguishers were mounted in close proximity to hand rails, with brackets that would allow the fire extinguishers to become easily dislodged and fall to the floor. A nail was observed to protrude from the bottom corner of a counter (seed table) in the activity room. A door was observed in resident room 103 to have a loose plastic cover with a chipped and sharp edge. An interview conducted with the Housekeeping/Maintenance Supervisor on 08/11/11, at 2:15 PM, revealed staff submitted work orders for maintenance requests of items in need of repair and the work orders were reviewed and prioritized for repair. Additional interview revealed the Housekeeping/Maintenance Supervisor toured the facility daily to identify housekeeping/maintenance concerns. According to the Housekeeping/Maintenance Supervisor, she was not aware the fire extinguishers could become easily dislodged from the wall bracket, or of the nail protruding from the edge of the seed table counter or the sharp edge on the resident door in room 103. A review of uncompleted facility work orders revealed no work orders had been received for repair of the seed table in the activity room or the resident's door in room 103.	F 323			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364			

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F 364	<p>Continued From page 4</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide foods that were palatable and at a preferable temperature during the evening meal on the Sterling Place Unit and the main dining room on 08/09/11.</p> <p>The findings include:</p> <p>An interview conducted with the Dietary Manager (DM) on 08/09/11, at 7:15 PM, revealed the facility did not have a specific policy/procedure related to meal service.</p> <p>Observation of the evening meal service on 08/09/11, at 5:10 PM, in the main dining room of the facility revealed three unsampled residents (Residents #17, #32, and #33) complained the fish that had been served had not been cooked properly and "the middle portion of the fish had not been cooked." All three residents stated they could not eat the fish because it was not done and was cold in the middle. The fish was light brown in color and the breading appeared moist.</p> <p>A food palatability test was conducted of a serving of fish from the kitchen. The temperature of the fish was 160 degrees Fahrenheit (acceptable temperature) and the fish tasted crispy, warm, and brown in color.</p> <p>Observation of the evening meal service on</p>	F 364			

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F 364	<p>Continued From page 5</p> <p>08/09/11, revealed a food cart was delivered from the kitchen in a closed, unheated cart to the Sterling Place Unit of the facility at 6:35 PM. The last tray was removed from the food cart at 7:08 PM, 33 minutes after the food cart was delivered to the floor. A food palatability test was conducted of the food items from the last tray on 08/09/11, at 7:08 PM. The food palatability test revealed the pureed tuna tasted warm at 115 degrees Fahrenheit, the mashed potatoes at 102 degrees Fahrenheit and pureed vegetables at 100 degrees Fahrenheit both tasted lukewarm, and the vanilla pudding at 60 degrees Fahrenheit tasted cool but was not cold.</p> <p>A group interview was conducted on 08/10/11, at 10:00 AM, with eight alert/oriented residents. Residents stated foods were not always as done as they should be when served. The residents also stated they had sometimes been served food cold that should be served hot.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #6 on 08/09/11, at 7:10 PM, revealed usually two SRNAs pass the evening meal trays to approximately 25 residents on the Sterling Place Unit. The SRNA revealed it usually took 30 to 45 minutes each night to pass the evening meal trays to the residents on the Sterling Place Unit of the facility. The SRNA stated the two SRNAs were also responsible to feed the residents that have been assessed to require assistance with feeding. The SRNA stated she had never been told by the facility how long a tray can be left in the food cart before it needed to be replaced with another tray due to unacceptable temperatures.</p>	F 364			

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F 364	Continued From page 6 An interview conducted with the Dietary Manager (DM) on 08/09/11, at 7:15 PM, revealed the food trays should be distributed within 30 minutes after the food cart has been delivered to the floor. The DM also stated she audited test trays for quality during breakfast and lunch service once or twice a week but never audited trays during the evening meal service.	F 364			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441			

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F 441	<p>Continued From page 7</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to establish and maintain an Infection Control Program to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease. During the evening meal on 08/09/11, at 6:10 PM, staff members failed to wash/sanitize their hands during the delivery of resident meal trays on the Lakeview Unit.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Universal Precautions (dated 06/01/11) revealed universal precautions were indicated for all residents. Further review of the policy revealed handwashing was indicated after contact with blood/body fluids, in between resident contacts, before clean procedures, after dirty procedures, and when leaving an isolation room.</p> <p>Observation on 08/09/11, at 6:10 PM, revealed CNA #1 delivered a meal tray to an unsampled resident that resided in room 10. CNA #1 placed</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>the resident's tray on the rolling overbed table and positioned the table within the resident's reach. The resident requested a substitute meal and CNA #1 obtained a walkie-talkie from her uniform pocket and alerted staff at the nurses' station of the resident's request. CNA #1 returned to the meal cart and delivered a meal tray to a resident in room 3. CNA #1 failed to wash/sanitize her hands between resident contact.</p> <p>Further observation of meal tray delivery revealed CNA #1 entered resident room 7 to deliver the evening meal tray. CNA #1 placed the meal tray on the resident's rolling overbed table. CNA #1 used a hand crank at the foot of the resident's bed to raise the head of the bed and then positioned the table in front of the resident. CNA #1 retrieved a cordless phone that was on the overbed table and placed the cordless phone in her uniform pocket. CNA #1 returned to the meal cart to obtain another tray and failed to wash/sanitize her hands.</p> <p>CNA #1 delivered a meal tray to an unsampled resident in room 9. CNA #1 positioned the rolling bedside table near the resident, placed a clothing protector on the resident, put on gloves, and proceeded to feed the resident without washing/sanitizing her hands.</p> <p>Interview on 08/09/11, at 7:10 PM, with CNA #1 revealed when delivering meal trays, hands should be washed after the delivery of trays to both residents in the room. CNA #1 revealed hands should be washed after resident contact. CNA #1 stated she just failed to wash/sanitize her hands during the meal tray pass as required.</p>	F 441			

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F 441	Continued From page 9 Interview on 08/10/11, at 3:00 PM, with the Director of Nursing (DON) revealed hands should be washed after providing care to residents; between any resident contact, or if staff touch any items in a resident's room.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain all essential electrical equipment in safe operating order. The facility's walk-in freezer was observed to have a large plastic container that collected condensation from the unit and there were icicles observed on the ceiling of the unit that had developed due to condensation. In addition, the air conditioner in resident room 209 was observed to leak water onto the floor. The findings include: 1. An interview conducted with the Dietary Manager on 08/11/11, at 2:30 PM, revealed the facility did not have a policy on maintenance of essential electrical equipment. During the sanitation tour conducted on 08/11/11, at 2:00 PM, observation of the facility's walk-in freezer revealed the unit was not in optimum operating condition. Based on observation, a large plastic container had been placed under the	F 456		

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F 456	<p>Continued From page 10</p> <p>compressor/motor/fan to collect condensation from the unit and contained approximately a liter of frozen condensation. The condensation from the unit had the potential to drip on frozen foods available for resident use. In addition, three small icicles, approximately one and one-half inches in length, were observed at the seam of the metal ceiling plates that had developed as a result of condensation.</p> <p>An interview conducted with the Dietary Manager (DM) on 08/11/11, at 2:30 PM, revealed the frozen ice was a result of the collected drippings from the condenser/fan of the freezer. The DM further stated the facility maintenance man had replaced the freezer compressor recently but the compressor continued to leak. The DM stated the plastic container was placed under the compressor to collect the dripping condensation. The DM stated she/he was unaware the frozen icicles had formed at the junction of the metal ceiling seams and had created the potential for the condensation to build up on frozen foods that were to be served to the residents.</p> <p>2. A review of the facility policy titled Equipment Maintenance (dated 12/07/09) revealed electrical equipment in need of repair or problems discovered by facility staff would be reported to the center manager for immediate attention.</p> <p>Observations conducted during an environmental tour on 08/11/11, at 2:05 PM, revealed the air conditioning unit in resident room 209 had leaked water onto the floor and a blanket had been placed on the floor to absorb the water.</p> <p>An interview conducted with the</p>	F 456		
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F 456	Continued From page 11 Housekeeping/Maintenance Supervisor on 08/11/11, at 2:15 PM, revealed the Housekeeping/Maintenance Supervisor was not aware the air conditioning unit in room 209 was leaking water onto the floor. A review of uncompleted work orders revealed no work order for the repair of any leaking air conditioning unit.	F 456			