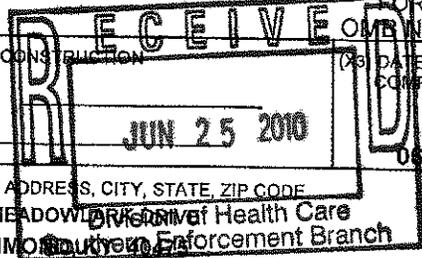


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLAND DRIVE RICHMOND, SOUTH CAROLINA 29224
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(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
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F 000	INITIAL COMMENTS	F 000		
F 151 SS=B	<p>A standard health survey was conducted on June 1-3, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to enable five (5) of twenty-four (24) sampled residents the right to exercise their rights to vote (Residents #16, #17, #18, #19 and #20). Additionally, the facility failed to have in place a system to ensure any resident who wanted to votes was afforded the opportunity.</p> <p>The findings include: During a group interview conducted on June 1, 2010, at 3:30 p.m., three of the five residents present voiced they did not vote during the recent election. Residents #16, #17, and #20 stated they were not afforded an opportunity to vote outside the facility, or to vote per absentee ballot.</p> <p>An interview conducted with the Activities Director (AD) on June 3, 2010 at 9:05 a.m., revealed the AD had been in the AD position since April 2010. The AD stated the AD was not aware that he/she</p>	F 151		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *C. L. King* TITLE: Administrator DATE: 6/25/10

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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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(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 151	Continued From page 1 was responsible to contact the local clerk's office to obtain the absentee ballots for residents in the facility to exercise their right to vote until May 18, 2010, the day of the election. The AD stated an assessment had been conducted to identify which residents wanted to vote and six residents in the facility had expressed the desire to vote. An interview conducted on June 3, 2010, at 1:50 p.m., revealed resident #19 stated the resident wanted to vote in the election. An interview conducted with resident #18 on June 3, 2010 at 1:45 p.m., revealed this resident expressed a desire to vote, but did not get to vote in the May 2010 election. A review of the facility's policy/procedure (dated January 2009) related to resident voting revealed provisions would be made and documented to allow the resident to become a registered voter, if desired. The policy/procedure stated each resident would be asked about the desire to vote upon admission and a Voter Registration Request would be completed and placed in a file in the Activities Department. The policy/procedure further required absentee ballots be provided to each resident and returned to the Supervisor of Elections after being completed by the resident.	F 151	1. Residents #16, 17, 18, 19, 20 have had addresses changed and or become registered voters. Absentee ballots will be requested to allow vote in the November 2010 elections. 2. All residents have been interviewed to determine desire to vote. Any resident registered to vote and desiring to vote has had an address change form submitted, any resident desiring to vote, but not a registered voter will have a voter registration form submitted. Once all residents desiring to vote registrations have been processed and notification of polling place received, an absentee ballot will be requested for the November 2, 2010 election. 3. The new activity director is aware of this Regulation and will be following policy and procedures for keeping all residents desiring to vote registered and providing absentee ballots. Administrator will monitor that all resident are allowed the opportunity to exercise their rights to vote. 4. The QA committee will review all new admissions for 30 days to validate their desire to vote has been documented and their voter information forwarded to the county clerk. 5. Date of compliance July 16, 2010		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under				

A. Are you a citizen of the United States of America? YES NO

If you checked "no" in response to either of these questions, do not complete this form.

B. Will you be 18 years of age on or before election day? YES NO

Check one:		FOR CLERK USE ONLY			
<input type="checkbox"/> New Registration	<input type="checkbox"/> Address Change	PRECINCT CODE	PRECINCT NAME	TOWN	OTHER CODE
<input type="checkbox"/> Party Change	<input type="checkbox"/> Name Change				
Social Security Number		Date of Birth (M-D-Y)	County (where you live)	Work Phone	Home Phone

Female Male

Last Name First Name Middle Name Suffix (circle one)
 Jr. Sr. II III IV

Address where you live (do not give PO address): Apt. # City Zip Code

Address where you get your mail (if different from above): Apt. # City Zip Code

Party Registration—check one box

Democratic Party
 Republican Party
 Other _____
 (write name above)

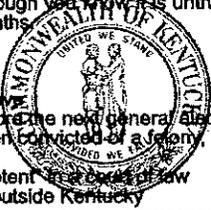
If you select "Other" as your party affiliation, you are eligible to vote for only nonpartisan offices in any primary election. You may vote for any candidate in all general or special elections. Only persons timely registered shall have the right to vote.

WARNING: If you sign this statement even though you know it is untrue, you can be convicted and fined up to \$500 and/or jailed up to 12 months.

Voter Declaration—read and sign below

I swear or affirm that:

- I am a U.S. citizen
- I live in Kentucky at the address listed above
- I will be at least 18 years of age on or before the next general election
- I am not a convicted felon, or if I have been convicted of a felony, my civil rights must have been restored by executive pardon
- I have not been judged "mentally incompetent" in a court of law
- I do not claim the right to vote anywhere outside Kentucky



X Signature Date

NOTE: You may change your political party affiliation at any time on or before December 31* to remain eligible to vote in the following primary election.

TWO WITNESSES REQUIRED IF "MARK" IS USED

Witnessed By: Witnessed By:

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	<p>Continued From page 2</p> <p>§1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community</p>	F 156	<ol style="list-style-type: none"> 1. Resident #14, 21, 22, 23, 24 have had notices sent again by certified mail. Notices included the appeal process. 2. An audit was completed on all Medicare cuts and exhaust for last 30 days to ensure certified notification had been sent and information on appeal processes. 3. BOM will ensure that all residents and or family members receive the included four letters upon cuts or exhaust of Medicare benefits. Administrator to monitor for 30 days. 4. QA committee will review and revise compliance plan as needed during monthly QA meeting. 5. Date of compliance July 16, 2010. 		

MADISON MANOR

NOTICE OF MEDICARE PROVIDER NON-COVERAGE

Patient Name:

Patient ID Number:

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT MEDICARE A SERVICES WILL END: **{insert effective date}**

- Your provider has determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
 - You may have to pay for any {insert type} services you receive after the above date.
-

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
 - If you choose to appeal, the independent reviewer will ask for your opinion and you should be available to answer questions or supply information. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, Medicare will not pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
-

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice.
- Call your QIO at: **Health Care Excel 1-812-234-1499 or 1-800-288-1499** to appeal, or if you have questions.

See page 2 of this form for more information.

Date: _____

**SCHEDULE OF CHARGES FOR
RICHMOND HEALTH & REHABILITATION COMPLEX – MADISON**

Room and Board	
Semi-private	<u>\$5053.00 /Month</u>
Private	<u>\$5735.00 /Month</u>
Semi-private converted to private	<u>\$NA /Month</u>
Bed Hold Charge	<u>\$163.00/\$185.00/Day</u>
Respite Care	<u>\$163.00/\$185.00/Day</u>
Personal Laundry Services	<u>\$N/C/Day</u>
Newspaper	<u>\$N/A/Item</u>
Resident Briefs	<u>\$6.00-\$17.00 /Package</u>
Cable TV	<u>\$N/A/Month</u>
Telephone Setup	<u>\$N/A/Setup</u>
Monthly Service	<u>\$N/A/Month</u>
Physical Therapy	
Therapy Evaluation	\$91.34 – 121.80 per Evaluation
Therapy Treatment	\$6.31 – 165.72 per 15 minutes
Occupational Therapy	
Therapy Evaluation	\$108.22 – 134.85 per Evaluation
Therapy Treatment	\$ 6.99 – 140.21 per 15 minutes
Speech Therapy	
Therapy Evaluation	\$100.05 – 156.20 per Evaluation
Therapy Treatment	\$7.05 – 149.50 per 15 minutes
Swallowing Treatment	\$19.33 – 195.18 per 15 minutes
Beautician Service	
Shampoo & Set	<u>\$10.00/Visit</u>
Set Only	<u>\$ 8.00/Visit</u>
Haircut	<u>\$ 8.00/Visit</u>
Permanent (includes haircut & style)	<u>\$35.00/Visit</u>
Color	<u>\$35.00/Visit</u>
Barber Services	
Haircut- every other month	<u>\$ 7.00/Visit</u>
Haircut- every month	<u>\$ 7.00/Visit</u>
Guardianship Petition Fee and Legal Expenses	Actual Cost Incurred by Center

Items marked N/C are included in your room and board rate.

Items marked N/A are items not available or not applicable.

As charges for Specialized Medical Equipment Rental, Prosthetics and Orthotics, Oxygen Supplies, Equipment, Gas, Enteral Supplies, Wound Care Products vary depending upon Resident's need and usage, please consult the Business Office, for charges.

A complete listing is available from the Business Office. Charges are subject to change.

MADISON MANOR**DETAILED EXPLANATION OF MEDICARE A NON-COVERAGE**

Date:

Patient Name:

Patient ID Number:

This notice gives a detailed explanation of why your provider has determined that Medicare coverage for your current {insert type} services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

- **The facts used to make this decision:**

- **Detailed explanation of why these services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:**

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at 1-812-234-1499 or 1-800-288-1499.

Form No. CMS-10124

Exp. Date 07/31/2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0953. The time required to distribute this information collection is 1 hour per notice, including the time to select the preprinted form, gather the needed information, complete the form, and deliver it to the beneficiary. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

OTHER APPEAL RIGHTS:

- If you miss the deadline for filing an immediate appeal, you may still be able to file an appeal with a QIO, but the QIO will take more time to make its decision.
- Contact 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

Required by Federal Law

MEDICARE DENIAL OF BENEFITS NOTICE

DATE: _____
TO: Name _____ Address _____ City/State/Zip _____
From: Facility _____ Address _____ City/State/Zip _____
RE: Resident Name _____ Medicare No. _____ Provider No. _____
Admission Date to Certified Bed _____

As required by Medicare, the beneficiary (resident) and/or his/her representative must be notified in writing when the services needed by the resident do not meet the criteria for coverage under the Medicare Program. In accordance with this regulation, we are notifying you of the following:

- We are placing the resident in Room # _____ which _____ IS _____ IS NOT CERTIFIED by Medicare. _____ You have voluntarily requested this placement.
ADMISSION DENIAL. On ____/____/____ we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services needed by the resident do not meet the requirements for coverage under Medicare because ____ 3-day qualifying stay was not met ____ 30-day transfer requirement was not met ____ 100 Medicare benefit days used ____ voluntary placement into a non-certified bed (Medicare benefits waived).
FACILITY DENIAL. On ____/____/____ we reviewed your medical information and have determined that the services furnished to you no longer qualified for payment by Medicare beginning ____/____/____.

THE SPECIFIC REASON IS:

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

Signature of Administrative Officer (NHA signature not required) _____ Date _____

Date sent _____ Date Sent to Physician _____
To: Resident _____ Legal Representative _____

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

I do want my bill submitted to the intermediary for a Medicare decision. NOTE: You will be informed when the bill is submitted. If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact _____

(Name and address of fiscal intermediary)

I do not want my bill submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if a bill is not submitted. NOTE: You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

VERIFICATION FOR RECEIPT OF NOTICE

This acknowledges that I received this notice of noncoverage of services under Medicare on ____/____/____.

Signature of resident or person acting on resident's behalf _____ Date _____

This is to confirm that you were advised of the noncoverage of services under Medicare by telephone on ____/____/____.

Name of Resident or Representative Contacted _____ Date _____

Signature of Administrative Officer _____ Date _____

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 156	<p>Continued From page 3</p> <p>spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written</p>	F 156		
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F 156	<p>Continued From page 4</p> <p>information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to include the verification of receipt of a Notice of Medicare Provider Non-Coverage denial notice and/or failed to include the information regarding procedures for an appeal in the denial notice for (5) five of five (5) residents (residents #14, #21, #22, #23, and #24) records reviewed that had received a denial notice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the denial notices for non-Medicare coverage for residents #14, #21, #22, #23, and #24 revealed that the notices sent to the resident/responsible party failed to include verification of receipt of the notice and/or failed to include the information regarding procedures for an appeal in the denial notice. <p>An interview conducted with the Office Manager (OM) on June 3, 2010 at 3:15 p.m., revealed the OM was responsible for issuing the denial notices to the residents/responsible parties. The OM stated the facility was not aware of the specific requirements of the denial notice until May 25, 2010. The OM stated the Corporate Clinical Reimbursement Specialist had conducted a conference call with the OM on May 25, 2010, and informed the OM of these requirements and the facility's policy/procedure related to Denial of</p>	F 156			

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F 156	Continued From page 5 Benefits.	F 156			
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES.</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to assure one (1) of twenty-four (24) sampled residents received activities in accordance with their assessed interests and in a manner adapted to meet their physical needs (resident #4). The facility failed to provide activities to meet the individualized needs of resident #4.</p> <p>The findings include: A review of the medical record for resident #4</p>	F 248			

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F 248	<p>Continued From page 6</p> <p>revealed the resident was admitted to the facility on January 12, 2007, with diagnoses that included Cerebrovascular Accident, Dementia, Osteoarthritis, Anxiety, Depression, and Pickers Syndrome.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated April 21, 2010, revealed the resident was assessed to have moderately impaired cognition and required extensive assistance with Activities of Daily Living (ADLs). The activity section of the MDS assessed resident #4 to be involved in activities one-third to two-thirds of the time.</p> <p>A review of the comprehensive care plan for resident #4 revealed interventions that included encouraging the resident to attend arts and crafts, exercise class, musical programs, church services, walk with staff, to give the resident washcloths to dust with as the resident enjoys the activity, and to watch TV in the CDE lounge. In addition, the facility would conduct one-to-one activities each week to provide socialization, tactile stimulation, and sensory stimulation. A review of the April and May 2010 activity logs revealed the only activity for resident #4 during the month of April was on April 13, 2010, when the resident attended Liberty Chapel, participated in arts and crafts, and went to the beauty shop. No other activities were recorded for the month of April. During the month of May 2010 resident #4 went to the beauty shop on May 6, 2010, and again on May 13, 2010. No additional activities were recorded for resident #4 for the month of May 2010.</p> <p>Observations conducted on June 1, 2010, at 2:40 p.m. and 5:20 p.m., and on June 2, 2010, at 8:30</p>	F 248	<p>F 248</p> <ol style="list-style-type: none"> 1. Resident #4 has had been encouraged to participate in activities more and resident is doing so, resident enjoys the music entertainment, sitting out side with other residents, watching TV and one to one interaction. 2. All residents care plan reviewed for activity accuracy by interdisciplinary care team and residents are being encouraged to be more involved with the activities they enjoy. More activities have been added to the calendar. 3. The interim activity director is making sure all residents are participating in activities and that all one on one activities are being completed each week. Resident activity participation records will be reviewed by Administrator weekly for validation that all residents are receiving opportunity to participate in the activities of their interest the next 30 days. 4. QA committee will review and revise compliance plan as needed during monthly meetings. 5. Date of compliance July 16, 2010 	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2010
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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 248	Continued From page 7 a.m., 9:35 a.m., 10:40 a.m., and 2:30 p.m., revealed the resident to be lying in bed with eyes closed. An interview with two Certified Nursing Assistants (CNAs) on June 2, 2010, at 2:40 p.m., revealed resident #4 remained in bed except during meal times. The CNAs stated the resident "never does anything except lay in the bed." An interview with the Activities Director (AD) was conducted on June 3, 2010, at 1:05 p.m. The AD stated he/she invited resident #4 to group activities but the resident usually refused. The AD further stated he/she did not document the resident's refusal to attend or that the AD had invited the resident. The AD also stated he/she was unaware resident #4's care plan intervention included a one-to-one intervention each week, and had not been providing the one-to-one activity.	F 248		
F 249 SS=E	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.	F 249	F 249 1. All residents at risk for potential harm 2. Present AD allowed to step back into CNA Position. Interim AD in place. 3. New AD with 2 years prior experience in a patient Activities program has been hired. New AD will attend Activity Certification training by the KAHCF September 20-24 2010. 4. QA committee will validate that new AD receives certification. 5. Date of compliance July 16, 2010	

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F 249	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have a qualified activities professional to direct the provision of activities for facility residents as required. A review of the qualifications of the facility's Activities Director (AD) revealed the AD had not received an approved training course for the provision of activities.</p> <p>The findings include:</p> <p>A review of the qualifications of the facility's Activities Director (AD) revealed the AD was not a qualified therapeutic recreation specialist or an activities professional who was licensed or registered; or had two years experience in a social or recreational program within the previous five years, one of which was full-time in a patient activities program in a health care setting; or was a qualified occupational therapist or assistant or has completed a training course approved by the State.</p> <p>A review of the personnel file for the current Activities Director (AD) revealed the AD was employed by the facility as a Certified Nursing Assistant (CNA) in February 2010 and became the AD in April 2010. There was no evidence in the personnel folder to indicate the AD had received training regarding the provision of activities for residents or met any of the other criteria.</p> <p>An interview with the AD conducted on June 3, 2010, at 1:05 p.m., revealed the AD had received</p>	F 249			

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NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 249	Continued From page 9 guidance from the Administrator and Regional Nursing Coordinator regarding the completion of documentation for activities and resident participation. The AD further stated he/she completed an activity assessment for residents and placed it in the chart, however, did not participate in completing the activities assessment for the Minimum Data Set Assessment, Resident Assessment Protocols, or Care Planning. An interview with the Interim Administrator conducted on June 3, 2010, at 3:00 p.m., revealed the AD had been promoted from CNA to AD and had not received any formal training for the position. The Interim Administrator stated the facility planned to have the AD attend approved training in the fall.	F 249		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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F 278	<p>Continued From page 10</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the comprehensive assessment accurately represented the resident's status for one (1) of twenty-four (24) sampled residents (resident #4).</p> <p>The findings include:</p> <p>A review of the medical record for resident #4 revealed the resident was admitted to the facility on January 12, 2007, with diagnoses that included Cerebrovascular Accident, Dementia, Osteoarthritis, Anxiety, Depression, and Picker's Syndrome. A review of the "Significant Correction of a Prior Quarterly Assessment" completed on April 21, 2010, revealed resident #4 to be involved in activities from one-third to two-thirds of the time.</p> <p>Observations of resident #4 on June 1, 2010, at 2:40 p.m., 4:00 p.m., and 5:20 p.m., revealed the resident to be in bed with eyes closed. On June 2, 2010, at 8:30 a.m., 9:35 a.m., 10:40 a.m., and 2:40 p.m., resident #4 was observed to be in bed with eyes closed. On June 2, 2010, at 2:40 p.m.,</p>	F 278	<p>F278</p> <ol style="list-style-type: none"> 1. Resident #4 MDS was corrected on 6/11/2010 to accurately reflect current status. 2. An audit of all current MDS assessments will be completed by the MDS Coordinator, Activity Director and the DON/Designee to ensure the activities section accurately reflects the residents current status by July 16, 2010. 3. RDCS to re educate MDS Coordinator, DON and Activities Director regarding policy for completing accurate comprehensive assessments focusing on activities section by 7/16/2010. 4. RDCS to audit 10 MDS assessments Q month for one month to ensure the assessment reflects each residents current status. 4. QA committee to review and revise plan during monthly QA meetings. 5. Date of compliance July 16, 2010. 		

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F 278	Continued From page 11 the surveyor asked the resident if he/she would like to go outdoors. The resident said yes and immediately got out of bed. Staff escorted the resident to the front porch to look at flowers. An interview with the Certified Nursing Assistant (CNA) on June 2, 2010, at 2:40 p.m., revealed the resident stays in bed most of the time. The CNA stated the resident stays in bed except for meals when he/she goes to the dining room. An interview with the Activities Director (AD) conducted on June 3, 2010, at 1:25 p.m., revealed the AD did not participate in the MDS assessment process. The AD stated the resident did not spend from one-third to two thirds of the time in activities as indicated on the MDS. A review of the activity participation log for the month of April for resident #4 revealed the resident attended activities one day, on April 13, 2010. No other activities were recorded for resident #4 for the month of April. An interview with the Regional MDS Coordinator Registered Nurse (MDSRN) conducted on June 3, 2010, at 2:05 p.m., revealed the MDSRN had completed a Significant Correction MDS on April 21, 2010, for resident #4. The MDSRN stated she was completing corrections on several assessments at that time and did not look at activities to verify the activity assessment was correct. The MDSRN further stated she "just didn't focus on activities."	F 278			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician's orders for one (1) of twenty-four (24) sampled residents (resident #4). Resident #4 had a physician's order for geri-sleeves to be worn when out of bed, however, geri-sleeves were not utilized for this resident.</p> <p>The findings include:</p> <p>A review of the medical record for resident #4 revealed the resident was admitted to the facility on January 12, 2007, with diagnoses that included Cerebrovascular Accident, Dementia, Osteoarthritis, Anxiety, Depression, and Picker's Syndrome. A review of the current monthly physician's orders for resident #4 revealed the resident was to wear geri-sleeves to the bilateral upper extremities when out of bed.</p> <p>Observations on June 1, 2010, at 11:50 a.m., and on June 2, 2010, at 12:00 p.m., revealed resident #4 to be out of bed, however, the resident was not utilizing geri-sleeves.</p> <p>An interview with the Certified Nursing Assistant (CNA) on June 2, 2010, at 4:50 p.m., revealed the CNA was not aware the geri-sleeves were not on the resident. The CNA stated, "They are supposed to be on the resident; I did not realize that they weren't."</p> <p>An interview with the Registered Nurse (RN) was conducted on June 2, 2010, at 4:55 p.m. The RN stated, "I knew the resident was supposed to</p>	F281	<ol style="list-style-type: none"> 1. Resident #4 M.D was notified of geri sleeves not being on 6/3/2010 and new orders received. 2. An audit of physician's orders will be completed by RDCS/DON/U.M to ensure all residents with orders for geri sleeves have them on by 7/16/10. 3. Education nurse to re educate nursing staff regarding following physicians orders and ensuring geri sleeves are on as ordered by July 16, 2010 DON/Designee to randomly audit that residents with physicians orders for geri sleeves have them on 3 times a week for a month.. 4. QA committee to review and revise plan during monthly QA meeting. 5. Date of compliance July 16, 2010. 		

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F 281	Continued From page 13 have them, but I did not monitor the CNAs to ensure that they were on."	F 281			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F334	1. Resident 9 was offered and informed of the risk and benefits of the flu and pneumovac vaccines on 6/3/10. Resident refused both vaccinations. 2. All active resident records have been reviewed by the nurse management team to determine if residents had been offered and/or received flu and pneumonia vaccines. Those identified as requesting pneumonia vaccination will receive by 6/25/2010. Flu vaccination will be administrated as requested during annual flu season. 3. All licensed staff will be educated by the EDT on Flu and pneumonia vaccine procedures for offering upon admission. This will be completed by 7/16/10. New admissions will be reviewed by the IDT team to assure residents are offered and/or administered flu and pneumonia vaccines per policy. 4. The QA to review and advise during monthly QA meeting. 5. Date of compliance July 16, 2010.		

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F 334	<p>Continued From page 14</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the resident's medical record included documentation regarding immunizations, as per facility policy, for one (1) of twenty-four (24) sampled residents (resident #9). Resident #9's medical record did not include documentation</p>	F 334			

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F 334	<p>Continued From page 15 indicating the resident either received influenza and pneumococcal immunizations, or did not receive the immunizations due to contraindications or refusal.</p> <p>The findings include:</p> <p>Resident #9 was admitted to the facility on December 31, 2009. A review of resident #1's medical record revealed no documentation regarding resident #9's influenza or pneumococcal immunization status. A review of the Immunization Record contained in the resident's chart revealed the form to be blank.</p> <p>An interview was conducted on June 3, 2010, at 12:40 p.m., with resident #9. The resident stated he/she was not asked on admission or since residing in the facility about the influenza/pneumococcal immunizations. Resident #9 stated he/she had not received the influenza immunization during the last influenza season (October 2009 through March 31, 2010) and to his/her knowledge had never received a pneumococcal immunization.</p> <p>An interview was conducted on June 2, 2010, at 4:00 p.m., with the Unit Manager (UM). The UM stated he/she "believed" the resident had received the vaccinations prior to admission to the facility; however, during a subsequent interview with the UM on June 3, 2010, at 1:45 p.m., the UM stated the facility could provide no evidence, and was unable to verify, if resident #9 had received the immunizations prior to admission to the facility. The interview further revealed the UM was responsible for obtaining verification of the residents' immunization status, and that the information was contained in the</p>	F 334			

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F 334	Continued From page 16 medical record, but the UM had failed to do so for resident #9. A review of the facility's Immunization policy/procedure with a revision date of November 2008 revealed the facility will counsel residents on the benefits and adverse effects of the vaccines prior to administration and place a signed form by the resident in the medical record indicating receipt of the information. Review of resident #9's medical record revealed no evidence the information/education had been provided regarding the benefits/risks of the immunizations, and no evidence as to whether resident #9 had been administered, refused, or had contraindications to the vaccines.	F 334			
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 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the foods served during the evening meal for the E Hall and for the A/B Halls on June 1, 2010, were palatable and served at the proper temperatures to prevent foodborne illness. In addition, four (4) of the five (5) residents attending the Resident Group Interview conducted on June 1, 2010, at 3:30 p.m., stated foods from all meals were frequently served cold.	F 364	F364 1/2. All residents at risk for potential harm. 3. Dietary Service Manager and or designee will do Dietary Services Validation Test Tray five times a week for thirty days. Administrator will validate test trays are being done. Resident Council will be asked about food temperatures. 4. QA committee will review and revise compliance Plan during monthly QA. 5. Date of compliance July 16, 2010		

EXTENDICARE

Health Services, Inc.

Dietetic Services Quality Validation Test Tray

Facility Name: _____

Date: _____

Person Completing Form: _____

Meal: _____

TEST TRAY AUDIT		DIRECTIONS: Each acceptable temperature on tray line and at point of service receives 1 point. Each positive response for "Taste" and "Appearance" receives 1 point. Each of the "Yes/No" questions below also count for 1 point for each "Yes" answer.			
FOOD CATEGORY	FOOD ITEM (list the actual food item)	TRAYLINE TEMP	TEMP AT POINT OF SERVICE	TASTE	APPEARANCE
Soup / Hot Cereal					
Salad					
Entrée					
Starch					
Vegetable					
Dessert					
Beverage					
Milk					
Garnish					
Time Cart Left Kitchen:		Time Cart Was Fully Served:		Was Cart Served in 20 Minutes or Less? Yes or No	
A full set of flatware was provided. Yes or No		No disposable service ware was used. Yes or No			
Total Points Possible:				Actual Points:	

TRAY ACCURACY		DIRECTIONS: Assess 5 random trays for accuracy in the following areas. Each correct area = 1 point for scoring.				
DHET	PREFERENCES	CONDIMENT S	MAIN PLATE ITEMS	BREAD, SALAD, DESSERT	GARNISH	BEVERAGE
Total Points Possible (35 Max):						

Trayline Temperatures - Hot food $\geq 140^{\circ}\text{F}$
Cold food $\leq 40^{\circ}\text{F}$

Point of Service Temperatures - Hot food $\geq 120^{\circ}\text{F}$
Cold food $\leq 45^{\circ}\text{F}$

SCORING	POSSIBLE POINTS	TOTAL POINTS	COMMENTS
TEST TRAY AUDIT			
TRAY ACCURACY	35		
GRAND TOTAL			PERCENTAGE:

*THRESHOLD FOR TEST TRAY IS 90% OR GREATER. IF A SCORE OF LESS THAN 90% IS ACHIEVED, AN ACTION PLAN SHOULD BE IMPLEMENTED.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2010
NAME OF PROVIDER OR SUPPLIER RICHMOND HEALTH AND REHABILITATION COMPLEX-MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(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 364	Continued From page 17 The findings include: Observation of the evening meal service revealed the first closed unheated meal cart was transferred from the kitchen to the E Hall on June 1, 2010, at 5:35 p.m. The last tray was served from the food cart at 5:55 p.m., and a sample resident tray was removed from the cart at 5:57 p.m. The food temperatures obtained from the dinner tray were as follows: Meat Loaf was 110 degrees Fahrenheit and tasted warm, Mashed Potatoes were 135 degrees Fahrenheit and tasted warm, Cream Style Corn was 104 degrees Fahrenheit and barely warm to taste, Pudding was 50 degrees Fahrenheit, Milk was 48 degrees Fahrenheit, and the Iced Tea (no ice) was 50 degrees Fahrenheit. Further observations during the evening meal on June 1, 2010, revealed a closed unheated meal cart was transferred from the kitchen to the A/B Hall at 6:04 p.m. The last tray was served at 6:24 p.m., and a sample resident tray was removed from the unheated cart at 6:25 p.m. Food temperatures obtained from the dinner tray were as follows: Meat Loaf was 110 degrees Fahrenheit and tasted cool, Mashed Potatoes were 92 degrees Fahrenheit and tasted cold, Corn was 100 degrees Fahrenheit and tasted cold, Pudding was 60 degrees Fahrenheit, Milk was 50 degrees Fahrenheit, and the Iced Tea was 52 degrees Fahrenheit. A review of the Food Temperature Record recorded by the Dietary Cook on June 1, 2010, prior to tray assembly, revealed the Meat Loaf was 190 degrees Fahrenheit, Mashed Potatoes were 180 degrees Fahrenheit, Corn was 180	F 364			

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F 364	Continued From page 18 degrees Fahrenheit, Pudding was 32 degrees Fahrenheit, and Milk was 30 degrees Fahrenheit. A review of the facility's policy/procedure related to Food Temperatures/Test Tray (dated July 2004) revealed the "Point of Service" temperatures required hot foods to be served at 120 degrees Fahrenheit, and 45 degrees Fahrenheit for cold foods. An interview conducted with the Registered Dietitian (RD) on June 3, 2010, at 10:30 a.m., revealed resident meal trays should be served to the residents within 20 minutes after the meal cart leaves the kitchen area. The RD stated the Department Managers were assigned to monitor tray delivery during meal service. The RD stated a problem had been identified on May 10, 2010, related to food temperatures and the corrective action had been to obtain a new tray for the resident. The RD further stated inappropriate food temperatures had not been identified as a consistent problem. During a Resident Group Interview conducted on June 1, 2010, at 3:30 p.m., four of the five residents attending the meeting stated that foods were frequently served cold and not palatable to taste. These four residents stated this occurred frequently during all meals served at the facility.	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.	F 441			

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F 441	<p>Continued From page 19</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure staff performed proper handwashing during meal service and after each direct resident contact.</p>	F 441	<p>F441</p> <ol style="list-style-type: none"> 1. Resident #3 has had no change of condition . 2. Random Meal Service observation will be completed to assure that staff are not touching anything dirty prior to serving resident's food. 3. Education nurse to re educate nursing staff and Department Heads regarding policy for hand washing by July 16, 2010. Department Heads to monitor meal service one time a day for 4 weeks for proper hand washing between meal trays. 4. QA committee to review and revise plan during monthly QA meeting. 5. Date of Compliance July 16, 2010. 		

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F 441	<p>Continued From page 20</p> <p>The findings include:</p> <p>Observation during the noon meal on June 1, 2010, at 12:32 p.m., revealed a Registered Nurse (RN) assigned to the AB Hall of the facility placed the tray of resident #3 on the resident's overbed table. The Registered Nurse (RN) then proceeded to lift the feet of resident #3 over the bottom of the overbed table. The RN then uncovered the tray of resident #3. The RN returned to the tray cart outside of the room and proceeded to deliver another resident's tray. The RN was not observed to wash/sanitize her hands.</p> <p>A review of the facility's policy for handwashing (not dated) revealed staff was required to wash their hands before entering a resident's room, after touching anything that may be considered dirty, and before handling a resident's meal tray.</p> <p>An interview was conducted on June 2, 2010, with the RN assigned to the AB Hall of the facility, and revealed the RN was aware of the requirement of washing hands before handling a resident's meal tray, and after touching anything that may be considered to be dirty. The RN stated he/she should have washed her/his hands after touching the shoes of resident #3, and prior to handling residents' meal trays.</p>	F 441			

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D E C E I V E D

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06/01/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2010
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K 000	INITIAL COMMENTS	K 000		
K 144 SS=F	<p>A life safety code survey was initiated and concluded on June 1, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to ensure the emergency generator located outside of the facility was being maintained according to NFPA standards. The facility failed to ensure that a written maintenance schedule was being kept on the emergency generator. This condition has the potential to affect all staff and residents. The facility has the capacity for 92 beds and had a census of 75 on the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on June 1, 2010, at 2:00 p.m., with the Director of Maintenance, a</p>	K 144	<p>K 144</p> <p>A written weekly preventive maintenance schedule has been planned for the generator. The plan includes the following:</p> <ol style="list-style-type: none"> 1. Oil and water levels. 2. Evidence of generator switch exercised and Logged. <p>Administrator will visually monitor this plan for next 30 days. Compliance date of July 16, 2010</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindi Simpson TITLE: Administrator DATE: 6/25/10

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

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K 144	<p>Continued From page 1</p> <p>record review of the generator set revealed there was no written preventive weekly maintenance schedule. A maintenance schedule was kept in the facility's computer system; however, the schedule did not contain an area to check the oil and water levels. In addition, there was no evidence the generator transfer switch was being exercised and logged once a month. An interview revealed the Director of Maintenance did check fluid levels weekly, but was not aware there should be a written schedule. In addition, the Director of Maintenance stated the generator automatically started and was unaware the transfer switch needed to be exercised and logged once a month.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer ' s recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a</p>	K 144		

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K 144	<p>Continued From page 2</p> <p>minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p>	K 144			