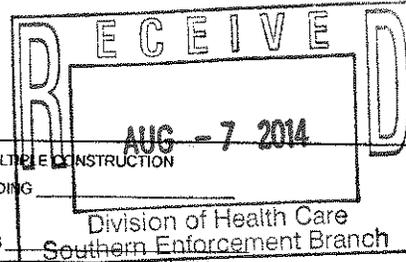


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  07/17/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522
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F 000	INITIAL COMMENTS	F 000	<p>This plan of correction is submitted under federal and state regulations and status applicable to long term care providers. This plan of correction does not constitute an admission of liability on part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyor's findings or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding the scope and severity regarding the deficiency are cited correctly. Furthermore, we request this plan of correction serve as our credible allegation of compliance.</p> <p style="text-align: center;"><u>Tag # 282</u></p> <p>1. The physician was notified by the charge nurse on 7/17/14 of residents' #1, #8, and #13's non-adherence to their written plan of care. New orders were received on 7/17/14 to discontinue those care planned interventions related to the residents' non-adherence. Each resident had their responsible party notified and their written plan of care updated accordingly. All residents have the potential to be affected.</p>	
F 282 SS=E	<p>A standard health survey was conducted on 07/15-17/14. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 the written plan of care for three (3) of seventeen (17) sampled residents (Residents #1, #8, and #13). A review of care plans revealed the facility had assessed Resident #1 to require the use of hipsters (pull on underpants with padding over the hip area); however, observations revealed the hipsters were not in use on 07/15/14, 07/16/14, or 07/17/14. Review of Resident #8's care plan revealed the facility assessed Resident #8 to require the use of TED (anti-embolism) hose; however, observations on 07/15/14, 07/16/14, and 07/17/14 revealed the TED hose were not in use by the resident. In addition, review of the care plan for Resident #13 revealed the facility assessed the resident to require oxygen at 2 liters per minute continuously; however, on 07/17/14, the facility failed to ensure the resident received the oxygen as planned.</p> <p>The findings include:</p>	F 282		

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE INTERIM EXECUTIVE DIRECTOR	(X6) DATE 8-7-2014
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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 282	<p>Continued From page 1</p> <p>A review of the facility policy, "Resident Care Plan," (dated December 2008) revealed the plan of care should include a review and evaluation of the care provided, and include a lack of progress and/or a change of approaches if needed.</p> <p>1. A review of Resident #1's medical record revealed diagnoses that included Muscle Weakness, Personal History of Falls, and a History of Traumatic Fractures. Review of Resident #1's written Plan of Care (dated 07/08/14) revealed the resident was to wear hipsters "at all times." In addition, a review of the facility's Care Directives guide for the Certified Nurse Aides (CNAs) revealed hipsters were to be worn as a safety device. A review of the quarterly Minimum Data set (MDS) dated 04/27/14 revealed facility staff had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was intact.</p> <p>Observation of Resident #1 on 07/15/14 at 2:00 PM, on 07/16/14 at 8:50 AM and on 07/17/14 at 10:00 AM revealed the hipsters were not in use.</p> <p>Interview conducted with Resident #1 on 07/17/14 at 10:00 AM revealed the resident did not like to wear the hipsters and stated "they are too hot."</p> <p>Interview with Certified Nurse Aide (CNA) #2 on 07/17/14 at 10:15 AM revealed she was aware the use of the hipsters was on the care plan and that the resident was to wear the hipsters. However, the CNA stated the resident refused to wear the hipsters. According to the CNA, nursing staff was aware the resident refused to use the hipsters.</p>	F 282	<p>2. A 100% audit of residents care plans will be completed by 8/18/14 by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or MDS Nurse to identify any care plan not identifying each individual resident's needs. DON,ADON ,Unit Manager,Social Services Director and /or Activities Director to complete an audit of all care plans and CNA Care Directives to identify any care plan and /or care directive that does not meet the residents individual need (this will include issues with refusal of care). This will be completed by 8/20/2014. Any issue identified will have physician and responsible party notified and be immediately corrected.</p> <p>3. All licensed nurses were re educated on 7/25/14 by the Director of Nursing/ADON regarding physician notification of any refusal of care, following physician orders, care plan revision and initiation, reporting and documentation regarding refusal of treatment. Any nurse not in attendance will be re educated by the DON/ADON and/or Unit</p>	

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F 282	<p>Continued From page 2</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 07/17/14 at 10:20 AM revealed Resident #1 refused to wear the hipsters. LPN #2 said the use of the hipsters was also on the Treatment Administration Record (TAR) and stated dates had been circled on the TAR when the hipsters were not in use; however, review of the treatment record failed to reveal why the hipsters were not in use or if the resident had refused the treatment.</p> <p>Interview with the Unit Manager (UM) of the Hope Wing on 07/17/14 at 10:25 AM revealed Resident #1 refused to wear hipsters as care planned. According to the Unit Manager, when physician's orders were written, the nurses were to update the care plan. The UM also stated the nurse that completed the Minimum Data Set (MDS) assessment received a copy of the order. The Unit Manager stated nurses were to check the care plans to make sure the plans were accurate and up to date. According to the UM, the MDS Coordinator was also required to check the Treatment Administration Records (TARs) to determine if devices were in use in order to update the care plan accordingly. The Unit Manager acknowledged, based on documentation, the hipsters had not always been used for Resident #1 and that staff failed to document the reason. The Unit Manger said the nurses should have documented why the hipsters were not in use and should have modified the care plan if the resident refused to wear the hipsters.</p> <p>2. A review of Resident #8's medical record revealed the resident had diagnoses of Left Hip Fracture, Pain in Joints, Osteoarthritis, History of Right Hip Fracture, History of Heart Attack, and a</p>	F 282	<p><b>Manager prior to working their next shift.</b></p> <p><b>The DON, ADON, UM, or MDS nurse will audit 10 random care plans, care directives, and treatment records beginning week of 8/20/14 to ensure all residents' care planned interventions are in place to meet their individual needs. Any issue identified will be immediately corrected. These audits will be completed weekly x 4 weeks then monthly x 2 months.</b></p> <p><b>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</b></p> <p><b>5. Compliance Date – 8/25/14.</b></p>		

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F 282	<p>Continued From page 3</p> <p>Personal History of Falls. A review of the Care Plan dated 06/09/14 revealed staff was to apply TED hose in the morning and remove them in the evening for Resident #8. A review of the quarterly assessment dated 05/31/14 revealed the resident's BIMS score was 3, which indicated the resident's cognition was severely impaired. In addition, a review of the CNA Care Directive revealed staff was to put the TED hose on the resident in the morning and remove them in the evening.</p> <p>Observation of Resident #8 on 07/15/14 at 12:00 PM, 2:45 PM, and 5:15 PM, 07/16/14 at 8:45 AM, 10:00 AM, and 12:15 PM, and on 07/17/14 at 9:00 AM revealed the TED hose were not in use.</p> <p>Interview with Resident #8's family/friends revealed the TED hose were in the resident's closet but the resident refused to wear them.</p> <p>Interview with LPN #1 on 07/17/14 at 10:20 AM revealed Resident #8 refused to wear the TED hose, and the nurses were to document on the Treatment Administration Record (TAR) if the resident refused the treatment. LPN #2 acknowledged there was no documentation on the care plan, on the TAR, or in the nurse's notes that Resident #8 refused to wear the TED hose.</p> <p>Interview with the Unit Manager (UM) of the Hope Wing on 07/17/14 at 10:25 AM revealed the managers were to make rounds and monitor residents to ensure assistive devices, including TED hose, were in place. The UM said Resident #8 refused to wear the TED hose, and staff should have documented and updated the resident's care plan to reflect the resident's refusal to wear the hose.</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>3. A review of Resident #13's medical record revealed the resident had diagnoses of Coronary Artery Disease, Shortness of Breath with Exertion, and Hypertension. A review of the resident's Care Plan, dated 06/23/14, revealed staff had assessed the resident and noted the resident was to receive oxygen at 2 liters per minute via a nasal cannula. A review of the CNA Care Directive dated 07/17/14 also revealed oxygen was to be administered at 2 liters per minute via a nasal cannula. Review of the Admission assessment, dated 06/20/14 revealed staff had assessed the resident to have a BIMS score of 3, which indicated the resident's cognition was severely impaired.</p> <p>Observation of Resident #13 on 07/17/14 at 9:00 AM, 9:35 AM, and 10:00 AM revealed no oxygen was in place for the resident.</p> <p>An interview with Resident #13 was not attempted due to resident's cognitive status.</p> <p>Interview with CNA #3 on 07/17/14 at 10:00 AM revealed the resident removed the oxygen when he/she felt he/she did not need the oxygen.</p> <p>The Unit Manager of the Hope Wing acknowledged in interview conducted on 07/17/14 at 10:10 AM that staff had developed a care plan related to oxygen use for Resident #13 and initialed the Treatment Administration Record to indicate the resident's oxygen had been administered at 2 liters per minute. However, the UM stated Resident #13 often removed the oxygen him/herself when he/she did not want to wear the oxygen.</p>	F 282			

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F 282	Continued From page 5  Interview with the Minimum Data Set (MDS) Coordinator on 07/17/14 at 10:45 AM revealed staff should indicate on the resident's care plan if a resident refused care and/or treatments that had been care planned. In addition, the MDS Coordinator stated staff should document any time a resident refused care and/or treatment on the TARs along with the reason for the refusal, in order for staff to review and develop and/or update the plan of care.  Interview with the Director of Nursing (DON) on 07/17/14 at 2:25 PM revealed staff had reviewed and updated care plans "a few weeks ago." The DON said Unit Managers were required to review care and if it was determined a resident had refused care, the UM was required to review the care plan to determine if the care plan had been updated to reflect the resident's refusal. The DON stated Unit Managers were to conduct daily rounds to determine if care planned interventions had been carried out or for documentation of the resident's noncompliance with the care plan if the resident refused care. The DON stated she conducted rounds on a weekly basis and stated any issues were to be dealt with immediately and in-services conducted if indicated. According to the DON, staff had not identified any concerns related to care plans.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility maintenance logs, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible for two (2) of seventeen (17) sampled and eight (8) unsampled residents that had been identified to have wandering behaviors (Residents #7, #8, B, C, D, E, F, G, H, and I). Observations of the laundry room area revealed chemicals were present and the hot water temperature was 140 degrees Fahrenheit. Observations of the Faith Hall shower room revealed an electrical thermostat was uncovered and exposed and, as a result, could present an electrical shock hazard. In addition, the wood door to resident room 407 had areas of chipped wood with sharp splinters exposed.  The findings include:  1. An interview conducted with the Laundry Supervisor on 07/17/14 at 1:37 PM, revealed the facility did not have a policy regarding locking the facility laundry room.  A review of the facility Hazardous Materials Management Plan dated 09/19/13, revealed Department Heads had the responsibility to enforce policies and procedures and for identifying, handling, storing, using, and disposing of hazardous materials used in their departments.  Observation of the facility's laundry room on 09/17/14 at 9:49 AM revealed the room had two	F 323	<u>323</u>  1. Locks were installed on the Laundry Room doors on 7/17/14 by the Maintenance Department. A replacement thermostat cover was installed in the Faith Hall shower room on 7/17/14 by the Maintenance Department. The splintered entry door to resident room 407 was repaired on 7/17/14 by the Maintenance Department. The Director of Maintenance checked water temperatures in the laundry room, all shower rooms, and random resident rooms on 8/6/14 to identify any temperature above or below regulations in any area accessible to residents. No issues were identified. All residents have the potential to be affected.  2. A one-time audit of all other doors in common areas that did not lock or had no lock was completed by the Executive Director and Maintenance Director on 7/17/14. Any issue identified was immediately corrected. Maintenance Director conducted checks of all shower room thermostats to		

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F 323	<p>Continued From page 7</p> <p>doors; however, the doors could not be locked to prevent unauthorized entry into the room. Additional observation of the laundry room revealed a hand sink with a hot water temperature of 140 degrees Fahrenheit. Further observation revealed a laundry dispensing system attached to the wall which contained three opened containers of solid laundry chemicals. A review of the chemical containers and the Material Safety Data Sheets (MSDSs) for the chemicals observed in the laundry room revealed the Solid Surge Detergent was labeled as a "danger," could cause severe skin burns and eye damage, and was harmful if swallowed. In addition, the solid laundry softener indicated the chemical was a "danger" and could cause skin corrosion/irritation, serious eye damage/irritation, and was harmful if swallowed. The solid bleach observed in the laundry room was labeled as a danger, could cause serious eye damage/irritation, and was harmful if swallowed.</p> <p>A review of a list of wandering residents provided by the Director of Nursing on 07/17/14 revealed the facility had assessed ten residents that had wandering behaviors (Residents #7 #8, B, C, D, E, F, G, H, and I).</p> <p>An interview conducted with a Laundry Aide on 07/17/14 at 10:00 AM revealed the Laundry Aide had worked at the facility for five years. According to the Laundry Aide, the laundry door had never had a locking device and was unlocked when the staff left the laundry to deliver resident clothing or when they had completed their duties for the day. Further interview revealed although residents could access the laundry area through the unlocked doors, the Laundry Aide was not aware of any resident entering the laundry area.</p>	F 323	<p>identify any thermostats without covers and resident room entry doors to assess for splintering on 8/7/2014. Any issue identified was immediately corrected. Maintenance Director checked water temperatures in laundry room, all shower rooms, and random resident rooms on 8/6/14 to identify any temperatures above or below regulations in any area accessible to residents. No issues were identified.</p> <p>3. All maintenance department staff were inserviced on 8/7/14 by the Executive Director regarding proper check of door lock operations in any area with hot water or chemicals, proper checking of thermostat covers, review of resident entry door maintenance and function, and correct water temperatures in areas accessible to residents.</p> <p>The Maintenance Director to audit common area door lock functioning, resident room entry door maintenance, shower room thermostat covers, and proper water temperature weekly in</p>		

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F 323	<p>Continued From page 8</p> <p>An interview conducted with the Laundry Supervisor on 07/17/14 at 1:37 PM revealed the laundry room door did not have a lock and the supervisor had not considered the area a hazard to residents.</p> <p>An interview conducted with the facility Administrator on 07/17/14 at 3:10 PM revealed the Administrator had made rounds of the facility daily to identify concerns related to resident safety and was not aware the laundry room did not have locks or that residents could access a hazardous area.</p> <p>2. An interview with the facility Maintenance Director revealed the facility did not have a specific Maintenance policy but used the "Direct Supply TELS" system (a computerized maintenance schedule) to identify concerns that were a risk to resident safety.</p> <p>Observations conducted during an initial tour of the facility conducted on 07/15/14 at 8:50 AM and an environmental tour on 07/17/14 at 2:01 PM revealed the cover of a thermostat located on a wall in the Faith Hall shower room was missing, with electrical contacts exposed, and presented a shock hazard if contact was made with the thermostat. In addition, an entry door to resident room 407 was observed to have sharp wooden splinters, one-half inch in length, exposed.</p> <p>A review of the daily and weekly "TELS" maintenance checks completed for June 2014 and July 2014 revealed the resident room doors and baths were required to be checked by the Maintenance Director daily.</p>	F 323	<p>random resident rooms and all shower rooms x 4 weeks then monthly x 2 months beginning week of 8/11/14 to ensure no resident is exposed to an unsafe condition.</p> <p>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</p> <p>5. Compliance Date – 8/25/14.</p>	

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F 323	Continued From page 9 An interview conducted with the Maintenance Director on 07/17/14 at 2:15 PM revealed the Maintenance Director made rounds daily and had not identified the splintered door or the uncovered thermostat.	F 323	<p align="center"><b>Tag # F 364</b></p> <ol style="list-style-type: none"> <li>No residents were identified. All residents have the potential to be affected.</li> <li>The Dietary Manager and all department managers (ED, DON, ADON, Unit Managers, Director of Social Services, Director of Rehab, and Director of Activities) completed an interview with all cognitive residents to identify issues with cold food or undesirable taste by 8/7/14. Any issues will be immediately corrected.  The Director of Nursing, Assistant Director of Nursing, Unit Managers, or MDS nurse completed a one-time audit of meal service to include tray delivery to identify any issues with cold food, tray deliver timeliness, and palatable foods at correct temperature on 8/7/14. Any issues were immediately corrected.</li> <li>The RD inserviced the dietary manager and all dietary staff on 8/6/14 regarding correct temperature of food to be</li> </ol>		
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure foods were palatable and at the proper temperature for residents on the back portion of the Faith Hall of the facility during the lunch meal on 07/15/14. A test tray conducted for a pureed tray on 07/15/14 revealed food items were not palatable and not at the appropriate temperature.</p> <p>The findings include:</p> <p>Review of the Food Preparation policy (dated 01/01/07) revealed foods should be prepared by methods that conserve nutritive value, flavor, and appearance. The policy further revealed foods served to residents should be palatable, attractive, and served at the appropriate temperature.</p> <p>Observation of the lunch meal on 07/15/14 revealed a closed cart that contained 12 trays</p>	F 364			

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F 364	<p>Continued From page 10</p> <p>was transported from the kitchen to the back portion of the Faith Hall of the facility at 12:10 PM. The last tray was intercepted at 12:45 PM (35 minutes later) and food temperatures were obtained with facility staff. The temperature of the pureed spaghetti with meat sauce was 126.1 degrees Fahrenheit and tasted warm, the pureed Italian vegetables was 112.4 degrees Fahrenheit and tasted tepid, and the pureed white bread was 85.5 degrees Fahrenheit and tasted cold.</p> <p>Interview conducted during the group interview on 07/15/14, at 4:00 PM, with seven alert residents revealed the residents were served cold food items.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 07/17/14, at 2:00 PM, revealed the CNAs were responsible to complete tray delivery within one hour of delivery after the food cart was delivered from the kitchen. The CNA stated this included resident tray setup, feeding the residents, tray pickup of the meal trays, and returning of the cart to the kitchen area. CNA #1 stated she was not aware of a specific time assigned for tray delivery. The CNA stated tray delivery and feeding of residents usually took up to 30 minutes to complete. CNA #1 further stated she was not aware of any resident complaints of cold foods.</p> <p>Interview with the Director of Nursing (DON) on 07/17/14, at 2:30 PM, revealed the facility had monitored meal trays and food temperatures during the past two weeks for all meals and had not identified any concerns with cold foods. The DON stated tray delivery and feeding of residents should take staff 15 to 20 minutes to complete once the cart had been delivered to the hallway. According to the DON, the process of tray</p>	F 364	<p>palatable and at the preferred temperature, following recipes, and tasting food prior to serving to ensure food being served is palatable.</p> <p>The SDC(Staff Development Coordinator)/DON and or Unit Managers will re educate all nursing staff on or before August 11, 2014 related to time frame to serve trays, when to have trays replaccd, and to ensure substitutes are offered.</p> <p>Dietary staff will test and record temperature of trays with each meal prior to sending the trays to the units to be served starting 8/7/14.</p> <p>Nursing staff will serve all meal trays in 15-20 minutes after receiving them on the unit. Any tray not served in 15-20 minutes will be returned to the kitchen to be replaced with a new meal. A department manager will be assigned to each meal three times per week to monitor that trays are served timely and residents are offered a substitute if desired x 30 days beginning 8/11/14.</p>		

F 364 CONTINUED

The Director of Social Services will interview 5 residents on each hall weekly to ensure food temperature, taste, and flavor are adequate beginning 8/11/14 x 30 days. The Dietary Manager will do point of service temperatures on 10 trays that are served on the hall weekly x 4 weeks beginning 8/11/14. Then monthly x 2 months.

Dietary Manager will audit dietary staff daily (Monday through Friday) x one week, weekly x 4 weeks, and monthly x 4 months to ensure temperatures are being maintained during tray service.

Any issue identified will be immediately corrected.

4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision

F 364 CONTINUED

**recommendations. This will  
be ongoing until issue is  
resolved.**

**5. Compliance Date – 8/25/14.**

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F 364	Continued From page 11	F 364	<p style="text-align: center;"><b>F 367</b></p> <ol style="list-style-type: none"> <li>Resident # 4's charge nurse intervened and removed the potatoes. The physician was notified by the charge nurse that resident had received the potatoes and new orders were received to change resident's diet. No other residents were identified. All resident have the potential to be affected.</li> <li>Dietary Manager and Unit Managers will complete a 100% audit of tray cards compared to physician orders to identify all diets on tray cards are correct by 8/15/14. Any issue identified will be immediately corrected.</li> </ol> <p>A one-time audit of meal service will be completed by the Dietary Manager, DON, ADON, Unit Managers, Director of Social Services, Executive Director, and Director of Activities to identify any resident receiving food not on their diet by 8/15/14. Any issue identified will be immediately corrected.</p> <ol style="list-style-type: none"> <li>Dietary Manager will re educate all dietary staff regarding following tray</li> </ol>		
F 367 SS=D	<p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policy for therapeutic diets, it was determined the facility failed to provide a therapeutic diet in accordance with physician's orders for one (1) of seventeen (17) sampled residents (Resident #4). Resident #4's physician's orders revealed bananas, orange juice, tomatoes, or potatoes were not to be included in the resident's diet. However, observation during the noon meal on 07/15/14 revealed facility staff served Resident #4 mashed potatoes.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Therapeutic Diets, with a revision date of 01/01/07, revealed therapeutic diets were prepared and served according to written orders from the attending physician to assist in managing problematic health conditions.</p> <p>A review of the medical record for Resident #4 revealed the facility admitted the resident on 11/04/13 with a diagnosis of Chronic Kidney</p>	F 367			

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F 367	<p>Continued From page 12</p> <p>Disease. Additional review of the record revealed the physician had requested facility staff not to serve bananas, orange juice, tomatoes, and potatoes to Resident #4 due to special diet restrictions.</p> <p>Observation of the lunch meal on 07/15/14 at 12:00 PM revealed Resident #4 was delivered and served a tray by Certified Nurse Aide (CNA) #4 which contained mashed potatoes. The resident was observed to eat the potatoes until a nurse removed the resident's tray and informed the resident he was not supposed to have potatoes.</p> <p>An interview conducted with CNA #4 on 07/15/14 at 12:15 PM revealed the CNA did not notice the instructions on the resident's tray card for no potatoes and according to the CNA, she should have obtained another meal tray for the resident.</p> <p>An interview conducted on 07/17/14 at 9:30 AM, with the Dietary Aide who checked Resident #4's tray for accuracy on 07/15/14 at the noon meal revealed the Dietary Aide had missed the potatoes on the tray and the tray was delivered to the floor to be served to the resident.</p> <p>An interview on 07/17/14 at 12:53 PM, with the cook who prepared Resident #4's lunch tray on 07/15/14 revealed the cook served the resident potatoes because tomato sauce was on the menu and the resident could not have tomatoes. The cook was not aware of what should have been served to Resident #4 instead of potatoes.</p>	F 367	<p>cards and physician orders by 8/11/14.</p> <p>DON/ADON/Unit Manager to re educate all nursing staff by 8/11/14 regarding following tray cards to ensure resident receives foods per physician orders.</p> <p>DON/ADON/Unit Managers will audit 6 tray cards at least three times per week beginning week of 8/13/14 to ensure tray card, physician orders, and resident's tray is provided per physician orders. These audits will continue x 4 weeks then monthly x 2 months. Any issue identified will be immediately corrected.</p> <p>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</p> <p>5. Compliance Date – 8/25/14.</p>		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 13</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure drugs and biologicals were stored and</p>	F 431	<p><b><u>F 431</u></b></p> <ol style="list-style-type: none"> <li>No specific residents were identified. All resident have the potential to be affected.</li> <li>DON/ADON/Unit Managers/MDS nurse to complete a one-time audit of med carts, med rooms, and medication refrigerators to identify any multi-dose vials not dated and any inhalers not stored upright per manufacturers guidelines by 8/15/14. Any issue identified will be immediately corrected with medication reordered at the expense of the facility.</li> <li>DON/ADON/Unit Managers/MDS Nurse will re-educate licensed nurses regarding following manufacturers recommendations for storage of drugs, dating multi-dose vials, and storing nasal sprays per manufacturers recommendations by 8/15/14.</li> </ol> <p>DON/ADON/Unit Managers/MDS nurse will audit med carts, med rooms, and medication refrigerators to identify any multi-dose vials not dated and any inhalers not stored upright</p>		

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F 431	<p>Continued From page 14</p> <p>labeled with currently acceptable professional principles. Observation of the medication room on the Hope Hall on 07/17/14, at 2:55 PM revealed a glass bottle of Tuberculin Purified Protein Derivative (PPD detecting tuberculosis TB infection) was stored in the refrigerator; however, staff failed to document the date the container was opened; Fluticasone Propionate 120 Metered Spray 50 micrograms (Nasal Spray) was stored in the medication drawer, however, staff failed to document the date the spray had been opened, and Ventolin HFA 200 INH 90 micrograms (Inhaler) was stored in a medication drawer; however, staff failed to position the inhaler in an upright position as recommended by the manufacturer.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles," revision date 01/01/13, revealed the facility staff should record the date opened on the medication container and ensure that medications and biologicals have not been retained longer than recommended by manufacturer or supplier guidelines. The policy also revealed the facility should store all medications and biologicals that required special containers for stability in accordance with manufacturer/supplier specifications.</p> <p>Observation of the medication room on the Hope Hall on 07/17/14, at 2:55 PM revealed staff had placed a glass bottle of Tuberculin PPD in the refrigerator that had been opened and staff failed to document on the bottle the date the container was opened. In addition, staff stored an opened box that contained Fluticasone Propionate 120</p>	F 431	<p>per manufacturers guidelines weekly x 4 weeks then monthly x 2 months. Any issue identified will be immediately corrected with medication reordered at the expense of the facility.</p> <p>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</p> <p>5. Compliance Date – 8/25/14.</p>	

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F 431	<p>Continued From page 15</p> <p>Metered Spray 50 micrograms (mcg) Nasal Spray in the medication drawer and failed to document the date the box that contained the nasal spray had been opened. In addition, Ventolin HFA 200 INH 90 mcg (Inhaler) was observed to be in a flat position in the medication drawer. According to the label on the medication box, the Ventolin Inhaler should be stored in an upright position.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 07/17/14 at 3:00 PM, revealed she was required to put the date on the bottles/boxes of any Inhalers or Tuberculin Purified Protein Derivatives when they were opened. The LPN stated she "guessed" they were just overlooked.</p> <p>Interview with LPN #3 on 07/17/14 at 3:15 PM revealed that Ventolin HFA Inhaler was to be stored in an upright position with the mouthpiece pointing down. The LPN stated she "just didn't pay attention to it today."</p> <p>Interview conducted with the Director of Nursing (DON) on 07/17/14 at 3:30 PM revealed the nurses were responsible to check the medication carts and medication rooms every shift to ensure drugs were labeled and stored properly. The DON further stated staff had not made her aware of any concerns related to improper medication storage.</p>	F 431	<p><b>Tag # 441</b></p> <ol style="list-style-type: none"> <li>1. <b>Unsampled Resident A's LPN cleansed the glucometer with Sani-Wipes (Bleach) after use on 7/15/14. The Medical Director was made aware of the improper cleaning of the glucometer on 7/15/14 with no concerns noted. All residents have the potential to be affected.</b></li> <li>CNA #1 did place a soiled tray onto a clean food cart containing one clean undelivered tray. No residents received a tray from that food cart after this occurred. Identified food cart was cleaned by dietary staff after that meal on 7/15/14. All residents have the potential to be affected.</li> <li>2. <b>DON/ADON/Unit Managers/MDS Nurse will complete a one-time observation of all nurses completing blood glucose testing and cleaning of glucometers to ensure all glucometers are cleaned correctly using the correct product by 8/15/14. Any issue identified will be immediately corrected.</b></li> </ol>		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</p>	F 441			

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F 441	<p>Continued From page 16 of disease and infection.</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 observation, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and</p>	F 441	<p>A one-time meal audit will be completed by department managers (DON,ADON, Social Services Director,Activities Director, Director of rehab, Dietary Manager, and ED) by 8/11/14 on each hallway to identify any staff member placing a soiled tray onto a clean cart with other undelivered food trays. Any issue identified will be immediately corrected.</p> <p>3. DON/ADON/Unit Managers will re-educate licensed nurses regarding the proper procedure and product to use to clean glucometers by 8/11/14.</p> <p>DON/ADON/Unit Managers will re-educate nursing staff regarding where to place soiled trays, not to place soiled trays and clean trays together, and infection control practices with meal delivery by 8/11/14.</p> <p>DON/ADON/Unit Managers will monitor at least two nurses weekly performing blood glucose testing and cleaning to ensure glucometers are cleaned with correct product beginning</p>	

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F 441	<p>Continued From page 17</p> <p>sanitary environment to prevent transmission of disease and infection. Observation during medication administration on 07/15/14 at 4:30 PM, revealed staff failed to clean/sanitize the glucometer (blood glucose monitoring device) with a product that kills bloodborne pathogens after she checked Resident A's blood glucose. In addition, staff was observed to place a soiled food tray onto a food cart containing one clean undelivered food tray.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Cleaning and Disinfection of the Glucometer," dated March 2010, revealed the glucometer would be cleaned with a Super Sani-Cloth (Germicidal Disposable Wipe with Bleach) or a product that kills hepatitis B and bloodborne pathogens after each use.</p> <p>Observation of blood glucose monitoring for Resident A on 07/15/14 at 4:30 PM revealed Licensed Practical Nurse (LPN) #1 cleaned the glucometer with a Sani-Hands Wipe (Hand Sanitizer containing alcohol and no bleach) after testing Resident A's blood glucose.</p> <p>Interview conducted with LPN #1 on 07/15/14 at 4:40 PM, revealed she was required to cleanse blood glucose monitoring devices with a bleach wipe after each use. The LPN stated the box for the Sani-Hands and the box for Super Sani-Cloths (Germicidal Bleach Wipe) sat side by side each other in the medication drawer on the medication cart and she must have "grabbed the wrong one."</p> <p>Interview with the Director of Nursing (DON) on 07/15/14 at 5:00 PM revealed staff was required</p>	F 441	<p>8/11/14 weekly x 4 weeks then monthly x 2 months.</p> <p>Department Managers will observe one meal pass on hallways per week beginning 8/11/14 to ensure no soiled trays are placed on a clean cart with undelivered meal trays and that staff are following infection control practices with meal delivery weekly x 4 weeks then monthly x 2 months.</p> <p>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</p> <p>5. Compliance Date – 8/25/14.</p>	

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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 18</p> <p>to clean glucometers with a bleach wipe between each use. The DON stated she randomly conducted spot checks to monitor staff to ensure glucometers were cleaned with a bleach wipe. The DON further stated no problems had been identified.</p> <p>2. Review of the facility's policy, Resident Dining Services, (dated 01/01/07) revealed all meal trays were to be served from the meal cart before soiled trays were returned to the cart.</p> <p>Observation of the noon meal at 12:45 PM on 07/15/14 revealed the clean meal cart contained one undelivered meal tray; however, continued observations revealed Certified Nurse Aide (CNA) #1 placed a soiled food tray back onto the clean meal cart directly above the undelivered meal tray.</p> <p>Interview with CNA #1 at 12:50 PM on 07/15/14 revealed the clean meal cart was the only place to put the soiled tray other than sitting the tray on top of the meal cart.</p> <p>Interview with the Nurse Consultant at 12:55 PM on 07/15/14 revealed staff should know not to put soiled trays onto a cart before all the clean trays had been served.</p> <p>Interview with the Dietary Manager at 9:40 AM on 07/17/14 revealed staff should wait until all trays were served before they put soiled trays on the cart due to cross-contamination.</p>	F 441			

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

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NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE AND ZIP CODE <b>945 WEST RUSSELL STREET ELKHORN CITY, KY 41522</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1980</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type III (unprotected)</p> <p>Smoke Compartments: 6</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in laundry and kitchen area.</p> <p>Sprinkler System: Complete sprinkler system (dry).</p> <p>Generator: Type 2 generator powered by diesel.</p> <p>A life safety code survey was initiated and concluded on 07/15/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance</p>	K 000	<p>This plan of correction is submitted under federal and state regulations and status applicable to long term care providers. This plan of correction does not constitute an admission of liability on part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyor's findings or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding the deficiency are cited correctly. Furthermore, we request this plan of correction serve as our credible allegation of compliance.</p> <p style="text-align: center;"><u>Tag # K147</u></p> <ol style="list-style-type: none"> <li>1. The IV pump in resident room 501 as well as medical equipment in resident rooms 505, 701, and 706 were plugged into existing wall plug outlets on 7/15/14.</li> <li>2. A 100% audit of all other residents' rooms for medical equipment plugged into multi-outlet adapters was conducted on 7/15/14 by RN Unit Manager with no further issues identified.</li> <li>3. Maintenance director or assistant will do audits of</li> </ol>	
K 147 SS=D		K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>INTERIM EXECUTIVE DIRECTOR</b>	(X6) DATE <b>8-7-2014</b>
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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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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
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K 147	<p>Continued From page 1 with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately twelve (12) residents. The facility has the capacity for 106 beds with a census of 77 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/15/14, at 11:00 AM with the Director of Maintenance (DOM), an Intravenous (IV) Pump that had an IV Drip was observed to be plugged into a multi-outlet adapter (power strip) in resident room 501. Power strips cannot be used for medical equipment or high-draw appliances to help prevent against electrical shock and fire.</p> <p>During the survey resident rooms 505, 701, and 706 were also observed to be utilizing power strips with medical equipment such as nebulizers, oxygen concentrator, and a BiPAP machine.</p> <p>An interview on 07/15/14, at 11:00 AM with the DOM revealed he has made staff aware not to use power strips with medical equipment.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 147	<p>residents' rooms for extension cords or surge protectors being used with medical equipment 1 time a week for 4 weeks and then bi-month for next 4 weeks and then one time a month the next 4 weeks. All staff education completed to the proper usages of extension cords or surge protectors only for resident's electronic equipment, never medical equipment.</p> <p>4. The Quality Assurance Committee consisting of at least the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Director of Rehab, Dietary Manager, Director of Maintenance, and Director of Activities will meet monthly beginning 8/2014 to review audit findings and make revision recommendations. This will be ongoing until issue is resolved.</p> <p>5. Date of Compliance-8/25/14</p>		

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K 147	Continued From page 2 Reference: NFPA 99 (1999 Edition).  3-3.2.1.2 D  2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			