

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

PRINTED: 10/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033
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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

A standard health survey was initiated on 09/24/13 and concluded on 09/26/13 with a Life Safety Code Survey conducted on 09/26/13. Deficiencies were cited with the highest scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.

F 221 483.13(a) RIGHT TO BE FREE FROM SS=D PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the restraint policy, it was determined the facility failed to ensure residents were not restrained unless for treatment of medical symptoms for two (2) of twelve (12) sampled residents. Resident# 6 and #12.

The findings include:

Review of facility's policy titled Physical Restraints (no date on the policy) revealed any resident considered for the use of a physical restraint would be assessed for appropriate need of the restraint. The Physical Restraint Evaluation form was to be completed for any resident considered for the use of a physical restraint. The assessment for determining the need for the use of the physical restraint would be discussed with the resident and/or responsible party, including

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The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and State law.

F 221

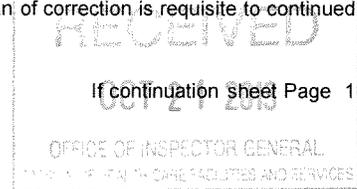
1. Resident #1 was immediately removed from the restraining seat belt by the Director of Nursing (DON) and assessed for any adverse physical or psychosocial effects due to the deficient practice of the facility. The resident was found not to have suffered any adverse effects.

Resident #12 was immediately removed from the restraining seat belt by the Director of Nursing (DON) and assessed for any adverse physical or psychosocial effects due to the deficient practice of the facility. The resident was found not to have suffered any adverse effects.

F-221 Continued next page.....

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 10/18/2013
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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 221 Continued From page 1

risks, benefits and alternatives. The assessment determining the need for the use of a physical restraint would be discussed with the resident's physician and an order obtained. The order needed to indicate the specific type, reason, frequency, and duration. The completion of the Restraint Evaluation would help determine the specific medical symptom the restraint was treating. The Evaluation would also help determine if the device was an Enabler or a Physical Restraint. A care plan would be developed for the use of the physical restraint that would include interventions to avoid decline in the resident's functional status and a plan to attempt reduction of the restraint. The Restraint Review Committee would meet monthly and discuss each resident utilizing a physical restraint and complete the Physical Restraint Review form.

Review of the Resident Roster Matrix (802), provided by the facility on 09/24/13, revealed the nursing facility indicated there were no residents who utilized a physical restraint. Review of the CMS 672 form revealed the same. Interview with the Director of Nursing (DON), on 09/24/13 at the time the matrix and 672 forms were provided, revealed there were no residents in the facility who utilized a physical restraint.

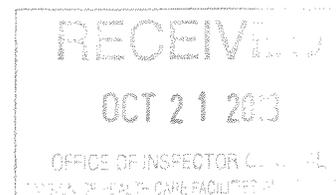
1. Observation of Resident #6, on 09/25/13 at 8:03AM, revealed the resident was sitting up in a wheelchair eating breakfast. An alarming Velcro seat belt was applied around the resident's waist and attached to the wheelchair. The belt was not released during the meal. Continued observations at 9:24AM, 10:24 AM, and 10:40 AM, revealed the resident sitting in the wheelchair with the seat belt applied. At 10:40 AM, Certified Medication Tech (CMT) #1 tested the battery on the alarming

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2. A audit was performed by The DON, Assistant Director of Nursing(ADON) and Minimum Data Sets Nurse(MDSN) on all residents of the facility to determine if other residents were at risk of this deficient practice on September 25, 2013, (See Exhibit #1: **Restraint Audit/Monitor**). No other residents were discovered to have been at risk.

3. A restraint assessment tool was developed by the Inter Disciplinary Team (IDT) consisting of a blend of Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, Medical Records Nurse (MRN), Activities Director (AD), Social Services Director (SSD), Director of Maintenance (DM), and Director of Housekeeping (DH), on September 25, 2013, to identify potential restraint events. (See Exhibit #2: **Restraint Policy with Tool**). The Restraint Assessment Tool will be utilized before any application of a seat belt or any device that may restrain or restrict the movement of a resident. Facility Policy was updated on September 25, 2013, by IDT and implemented on October 1, 2013. Staff was in-serviced September 26 –September 30, 2013 (See Exhibit 10: **General Safety, Infection Control, and Restraint in-service.**)

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F 221 Continued From page 2

seat belt. It was found to be working. Interview with CMT #1 at that time revealed the resident utilized the seat belt due to unassisted transfers with a history of falling. She stated she did not think the resident could release the belt. When requested to release the seat belt, the resident only looked at the CMT and could not understand the GMT's instructions. The resident did not release the seat belt and the CMT left the seat belt applied. Observation at 12:00 PM and 2:25 PM, revealed the resident was sitting in the wheelchair in front of the nurses' station with the seat belt applied. At 4:50PM, the resident was observed to be in an activity with one (1) to one (1) staff with the seat belt applied.

Observations, on 09/26/13 at 9:50AM and 10:55 AM, revealed the resident was sitting in the wheelchair with the alarming seat belt applied. At 1:53 PM, the resident was observed in the dining room eating lunch with the seat belt applied. Interview with CNA #2, at time of the observation, revealed the seat belt was not removed while the resident was in the wheelchair. She stated the seat belt was not removed during meals and she did not remove the seat belt during this meal service.

Review of the clinical record for Resident #6 revealed the facility admitted the resident on 02/04/13 with diagnoses of Dementia with Behavioral Disturbances, Depressive Disorder, and Anxiety. The initial Minimum Data Set (MDS) assessment, dated 02/11/13, revealed the facility assessed the resident to have a severe cognitive deficit with a Brief Interview Mental Status (BIMS) score of six (6) out of fifteen (15). In addition, the facility assessed the resident to require extensive assistance with bed mobility, transfers, and

F 221,

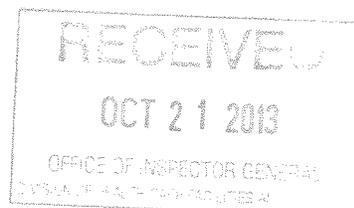
F-221 Continued.....

Updates included in the facility restraint policy are a restraint decisions tree that will be utilized in determining situations and devices constitute restraint. All licensed staff was in serviced by the DON, ADON and MDSN on September 26 through September 30, 2013. **(See Exhibit #2: Restraint Policy).**

4. A restraint monitor was developed by the IDT to assess and evaluated the use of restraints throughout the facility to ensure when restraints are applied or when a situation presents as a potential restraint that they are applied as a last resort, are correctly applied/utilized (if chemical restraint) and immediate steps are being undertaken to decrease and remove the restraint. The monitor will be performed by the DON, ADON or Unit Coordinator and by Shift Supervising Nurse on Weekends. The Monitor will be daily x 1 week, for residents with restraints, longer if 100% compliance is not achieved, then weekly x 4 weeks, (for residents with restraints) then monthly thereafter (for residents with restraints). The results of this monitor will be reported to the Quality Assurance for oversight, , **(See Exhibit #1: Restraint Audit/Monitor)**

5. Completion Date

10/5/13



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ambulation. The facility assessed the resident with an unsteady balance and gait. The facility assessed the resident at risk for falls. The Quarterly MDS assessment, dated 08/26/13, revealed no change in status with the resident, still at risk for falls and required extensive assistance with most Activities of Daily Living (ADL). The resident's BIMS score on the quarterly MDS was a six (6). Neither MDS assessments identified the resident's use of a seat belt.

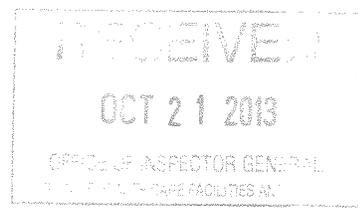
Continued review of the clinical record revealed on 05/22/13, the resident's physician ordered the Velcro self releasing seat belt with alarm related to a recent fall. Review of the general nursing note, dated 05/22/13, revealed the nurse spoke with the physician and requested the seat belt related to the fall. Continued review of the clinical record revealed no evidence an evaluation was conducted to determine if the device (seat belt) was a physical restraint. Review of the comprehensive care plan, revised 05/28/13, revealed the Velcro seat belt was placed as an intervention under the ADL deficit care plan. There was no care plan developed for the seat belt used as a device or restraint according to the facility's policy.

Interview with the DON, on 09/26/13 at 3:00PM, revealed she and the ADON were responsible for conducting the assessment for devices to determine if it was a physical restraint. She stated she had searched the clinical record and could find no evidence an evaluation of the seat belt was conducted. She stated she recalled talking with the ADON about the seat belt and they visually assessed the resident, but failed to document anything. She did not fill out the

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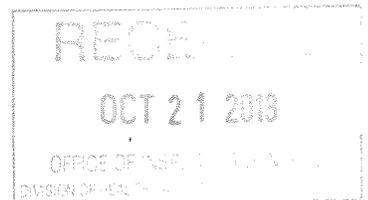
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F 221	<p>Continued From page 4</p> <p>Physical Restraint Evaluation form. She stated the resident could remove the belt at the time of application so they did not consider the device to be a physical restraint. The resident had a history of falls and would attempt to transfer without assistance. However, the resident had recent Psych hospitalizations and the DON stated the resident was more calm and did not attempt to transfer without assist now. She stated the assessment form should have been filled out. She had not considered the seat belt a restraint, therefore, a care plan was not developed for a reduction plan.</p> <p>Observation, on 09/26/13 at 3:30 PM, revealed the resident was sitting in a wheelchair in the East Hallway with the seat belt applied. The DON requested the resident to release the seat belt. The resident looked confused and could not release the belt. The DON stated the resident must have had a change since the last MDS assessment. However, she revealed since the seat belt had not been considered a physical restraint, the device was only reviewed quarterly with the MDS assessments, not monthly according to their policy.</p> <p>2. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 09/01/05, with diagnoses of Dementia, Anxiety, Rheumatoid Arthritis, and Constipation.</p> <p>Observation of Resident #12, on 09/26/13 at 2:00. PM revealed the resident had an alarming seat belt attached to the wheelchair. In addition, the resident had been observed throughout the Survey with the seat belt on when up.</p>	F 221		



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F 221 Continued From page 5 F 221

Review of the resident's annual MDS assessment, dated 05/03/13, revealed the resident did not require restraints and was coded a zero (0). The resident was also noted to have cognitive impairment and was documented with a BIMS Score of six (6), which showed the resident was not interviewable.

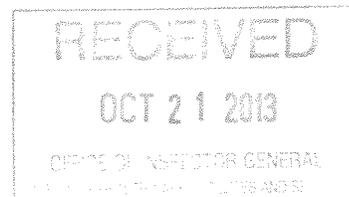
Further review of the plan of care, initiated on 02/23/12, for Resident #12 revealed the resident was at risk for falls related to being unaware of safety needs, which was related to Dementia. Interventions included providing the resident with a self-releasing wheelchair seatbelt with an alarm on while up and a personal alarm when in the bed. The alarm was to be checked each shift and as needed for functioning.

An attempt to interview Resident #12, on 09/26/13 at 3:00PM, revealed the resident was confused and unable to be interviewed. The resident provided non-pertinent answers to the questions. The resident was observed sitting in the recliner with both legs elevated.

Interview with Licensed Practical Nurse (LPN) #1, on 09/26/13 at 3:45 PM, revealed the resident was able to remove the seat belt and removed it all the time.

Interview with the Director of Nursing (DON), on 09/26/13 at 3:30 PM, revealed Resident #12 had the seat belt because of the risk of safety, and the seat belt was applied because the resident had been trying to stand on her own with risk of falls.

Interview with the MDS Coordinator, on 09/26/13 at 3:50PM, revealed all seat belts were assessed, by discussing each resident with each other, such



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F 221 Continued From page 6
as in the morning meeting. However, the Coordinator stated they do not document anywhere, and the information would not be Found on a form or in the nurses notes. The MDS, Coordinator stated she always had the resident attempt to remove the seat belt when she assessed the device, and stated Resident #12 had removed the seat belt a few minutes ago when asked. The MDS Coordinator stated they did not consider the alarming seat belt as a restraint for this resident, because she could remove it.

F 221

Review of the clinical record for Resident #12 and interviews with licensed nurses and the DON revealed no evidence the facility had assessed the device to determine if the seat belt was a Physical restraint for this resident.

F 323 483.25(h) FREE OF ACCIDENT
SS=E HAZARDS/SUPERVISION/DEVICES

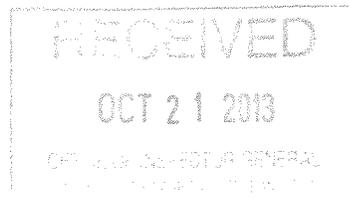
F 323

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of a Material Safety Data (MSD) sheet, facility policy, and Beauty Shop service agreement, it was determined the facility failed to ensure the residents' environment remained free from accident hazards. Observation during tour of the

1. A. Beauty shop- Residents were immediately removed from potential harm by the DON, an assessment was completed at that time to determine if any of the residents suffered any adverse effects of the deficient practice.
B. Whirlpool Room- The cabinet containing the chemicals was immediately secured by the Director of Nursing once discovered. A lock was placed on the door to prevent any access from residents. DON, ADON and MDSN assessed all ambulatory residents for signs of nausea, vomiting, salivation, or lacrimation

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whirlpool room revealed six (6) gallon jugs of body wash, one (1) gallon jug of whirlpool Disinfectant, and five (5) spray bottles of whirlpool cleaner disinfectant stored in an unlocked cabinet in the unattended whirlpool room. In addition, observation of the Beauty Shop revealed the Beautician left the room with three residents unattended with a curling iron on and multiple aerosol hair spray cans sitting on top of the counter. The census during the survey was forty-one (41) with eighteen (18) residents identified by the facility with a cognitive deficit and two (2) with wandering behaviors.

The findings include:

Review of the facility's policy titled Accident/Hazard Risk Assessment, last reviewed on 10/01/12, revealed all chemicals should be placed out of the reach of any resident. When not in use, all chemicals should be in a suitable locked container or cabinet. Review of the MSD sheet for the whirlpool disinfectant cleaner, date prepared 06/06/07, revealed the cleaner contained ammonium that would cause eye and skin irritation and could be harmful if swallowed or spray mist was inhaled.

1. Observation of the whirlpool room, on 09/24/13 at 10:30 AM, revealed the door was opened to the room and no one was in the room. Continued observation revealed a sink cabinet that was unlocked and contained one (1) gallon jug of whirlpool disinfectant, five (5) spray bottles of the same disinfectant, six (6) gallon jugs of body wash with a warning to call the poison center if swallowed, and one (1) aerosol can of hospital germicide. A lock was observed to be on top of the sink counter.

F 323

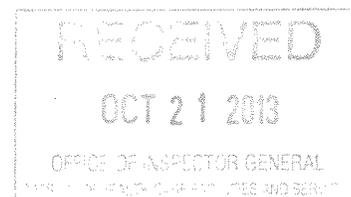
F-323 Continued

2. A & B- It was determined by the IDT Inter Disciplinary Team (IDT) consisting of a blend of Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, Medical Records Nurse (MRN), Activities Director (AD), Social Services Director (SSD), Director of Maintenance (DM), and Director of Housekeeping (DH), That due to the nature of the deficient practice, that all resident had the potential to have been effected.

3. A. The Beautician was educated not to leave the salon for any reason while there are residents present, potentially exposing them to risks of accidental harm related to the deficient practice on September 25, 2013 by the Administrator. **(See Exhibit # 3: Beautician education form).**

B. Mandatory in-services on facility safety and chemical storage were held for all staff on September 26, 2013-September 28, 2013 by the Director of nursing, ADON and MDSN. Staff was in-serviced September 26 -September 30, 2013 **(See Exhibit 10: General Safety, Infection Control, and Restraint in-service.)**

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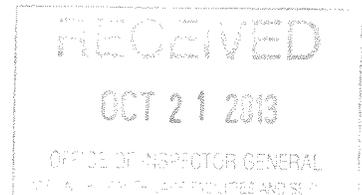
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F 323	<p>Continued From page 8</p> <p>Interview with CNA#4, on 09/24/13 at 10:45 AM, revealed she would Jock the cabinet where the chemicals are stored when she was done for the day. She acknowledged the whirlpool room had been left opened and unattended, but stated the nurses' station was close to the room and there was always someone there to observe the residents. However, observation, on 09/25/13 at 2:25 PM, revealed the nurses' station was empty and the door to the whirlpool room was opened and unattended.</p> <p>Interview with the Director of Nursing (DON), on 09/26/13 at 3:45PM, revealed the door to the whirlpool and shower rooms are to be closed and all chemicals should be stored in a locked cabinet whenever staff was not in the room. She stated CNAs and housekeeping have been trained to lock up all chemicals when not in use. She stated the nurses do supervise residents around the nurses' station, but was not responsible to ensure chemical are locked up. She had not completed audits of the whirlpool room to see if chemicals are stored properly.</p> <p>2. Review of the Beauty Shop services agreement, dated 06/06/08, revealed the Beauty Shop would be locked whenever the Beautician was not present In additon, chemicals would be stored in a locked cabinet</p> <p>Observation of the Beauty Shop, on 09/26/13 at 1:55 PM, revealed the door was opened with three (3) residents in the shop (one under the hair' dryer, the other two sitting in chairs with hair rollers in hair) unattended. A curling iron was turned on and heated, and four-five aerosol cans of hair spray sitting on top of counter. The</p>	F 323	<p>F-323 Continued.....</p> <p>A safety audit was developed to ensure that all chemicals are stored in secure locked cabinets and that the cabinets including the beauty shop were maintained in a locked status while not in direct observation by a staff member. The beauty shop will be monitored beginning September 26, 2013, by DON, ADON, MDSN, and Maintenance Director three times daily for a period of one week then daily x 2 weeks, weekly x 3 weeks, longer if 100% compliance is not maintained. The Administrator or designee will provide oversight by reviewing and evaluating effectiveness of the audits daily and will acknowledge by signing all audits (See Exhibit #4: Safety audit/Inspection)</p> <p>4. Safety monitoring for specific areas including beauty shop and whirlpool room were added to the maintenance safety checks that are reported monthly to the Quality Assurance Committee for oversight and direction, (See Exhibit #4: Safety audit/Inspection)</p> <p>5. Completed Date</p>	10/05/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033
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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 323 Continued From page 9
 Beautician came into the shop at 2:03PM. Interview with the Beautician revealed she had taken a resident back to their room. She stated she was suppose to stay in the Beauty Shop when unlocked and not leave it unattended. She stated nursing staff would help sometimes with transport, but she did not have a phone in the Beauty Shop to call them for assistance, so she would take the residents back to their room frequently.

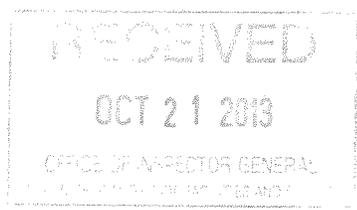
F 323

F 441 483.65 INFECTION CONTROL, PREVENT SS=D 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

F-441
 1. The falls mats in rooms #114 and #115 were removed from the resident rooms immediately and discarded.
 2. Due to the nature of the deficient practice it was determined by the Inter Disciplinary Team (IDT) consisting of a blend of Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, Medical Records Nurse (MRN), Activities Director (AD), Social Services Director (SSD), Director of Maintenance (DM), and Director of Housekeeping (DH), that all residents had the potential to be effected by the practice.

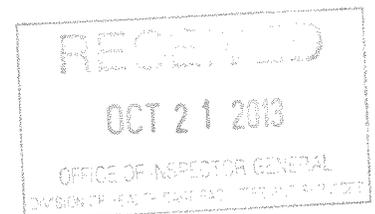
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F 441	<p>Continued From page 10</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 review of the facility's policy, it was determined the facility failed to implement their Infection Control Program consistently to prevent the transmission of disease and infection related to torn and dirty fall mats for two (2) of twelve (12) sampled residents. Observation of Rooms #114 and #115 revealed fall mats that were torn, ripped, and had foam exposed. In addition, the fall mats were dirty.</p> <p>The findings include: Review of the Infection Control Policy, not dated, revealed the facility would provide a safe and sanitary environment. The policy did not address specific instructions on how to care for fall mats to prevent the spread of disease.</p>	F 441	<p>F-441 Continued.....</p> <p>3. A room audit was developed to identify any potential infection control issues throughout the facility. The audit identifies: tears, rips and other physical aspects of equipment or medical devices that may contribute to the spread of infections. The audit is to be performed 1 x per week x 4 weeks, then bi weekly for a month (longer if 100% Compliance is not maintained). This will be performed by the Director of Nursing or designee, beginning September 26, 2013. Any torn ripped or otherwise dirty equipment or devices will be cleaned or replaced immediately and reported to Administrator for oversight. (See Exhibit #4: Safety audit/Inspection)</p> <p>4. Monitoring of the rooms will be performed monthly utilizing the Room inspection Audit/monitor and reported to the Quality Assurance Committee for oversight and direction. (See Exhibit #4: Safety audit/Inspection). Staff was in-service September 26 –September 30, 2013 (See Exhibit 10: General Safety, Infection Control, and Restraint in-service.)</p> <p>5. Date completed</p>
			10/05/13



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F 441 Continued From page 11

F 441

Observation of Room #114, on 09/26/13 at 4:10 PM, revealed the fall mat beside Resident #6's bed was torn and ripped at the seams exposing the inside foam.

Observation of Room #115, on 09/25/13 at 4:10 PM, revealed a fall mat beside Resident #3's bed that was torn with the inside foam exposed. The fall mat was dirty.

Interview with the Director of Nursing, on 09/26/13 at 3:45 PM, revealed she was responsible for providing the plastic covered foam fall mats. She stated whenever a fall mat became torn, the staff should inform her and she would provide a new one. She stated none of the staff had informed her of the need for a new fall mat. Although she did not perform room audits that would include inspections of the fall mats, the DON stated she was in and out of residents rooms daily and she failed to notice the poor condition of the fall mats in Rooms #114 and #115.

F 497 483.75(e)(8) NURSE AIDE PERFORM SS=E REVIEW-12 HR/YR INSERVICE

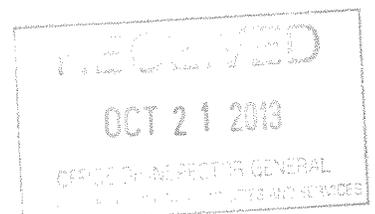
F 497

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse

F-497

1. Additional training for SRNA #2 and #4 was immediately provided bringing them into compliance. Residents that were in their care were assessed by the DON for adverse effect related to lack of appropriate training. The residents were found to have not suffered any negative effects related to the deficient practice.

Continued on next page.....



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F 497 Continued From page 12
aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
Based on interview, review of the facility education records, and policy, it was determined the facility failed to provide evidence that the required twelve (12) hour Certified Nurse Aide (CNA) training had been completed for two (2) of five (5) CNA training records reviewed (#2, and #4).

The findings include:

Review of the facility's policy regarding CNATraining, revised 08/01/13, revealed under Regular in-service education the facility would provide regular performance review and regular in-service education to ensure that individuals used as CNAs are competent to perform services as nurse aides.

Review of Nurse Aide #2's training file revealed a hire date of 08/05/11; however, there were only eleven (11) hours of training documented from the past year.

Review of Nurse Aide #4's training file revealed a hire date of 08/09/12; however, review of the CNA training hours revealed only eight (8) hours of training had been documented.

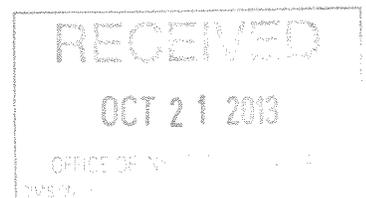
Interview with the RN Staff Development Coordinator (SDC), on 09/26/13 at 4:00 PM, revealed she had just taken over the training at the facility, and had found that many of last year's

F 497

F-497 Continued....

2. Due to the nature of the deficient practice it was determined by the Inter Disciplinary Team (IDT) consisting of a blend of Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, Medical Records Nurse (MRN), Activities Director (AD), Social Services Director (SSD), Director of Maintenance (DM), and Director of Housekeeping (DH), that all residents had the potential to be effected by the deficient practice.

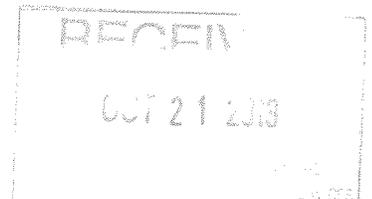
3. An audit was developed by the New Staff Development Nurse Supervisor to determine appropriate training regimens for the unlicensed staff, Processes and accountability. This was completed immediately, with oversight by the DON reviewing and signing audits (See **Exhibit #5: Immediate audit of SRNA staff**). The SDN will audit training weekly x 4 weeks, then monthly thereafter, with oversight by the administrator reviewing and signing audits. (See **Exhibit #6: SRNA Weekly Training Audit**)



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NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 497	Continued From page 13 education hours could not be found, since the previous SOC left. The SOC stated she would be developing a new system of documenting the hours, but had not been able to complete everything at this time. Interview with the Interim Administrator, on 09/26/13 at 4:30 PM, revealed each month, he reviewed a copy of the list of in-services, and who attended and presented the in-service. The Administrator also stated that all of the past year of in-services were missing, and they had not been able to locate them. In addition, the Interim Administrator revealed they had not had an In-service Coordinator to keep up with the hours until recently.	F 497	F-497 Continued..... 4. The SDN will complete a monthly monitor of SRNA training and education hours, this will include title date of training as well as contact hours received. This is to be submitted to the Quality Assurance Committee for input and direction. (See Exhibit #7: Continuing Education Log) 5. Date completed. 10/05/13



DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATE IDENTIFICATION NUMBER AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 185437	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 -MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033
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K 000 INITIAL COMMENTS

CFR: 42 CFR §483.70 (a)
BUILDING: 01
PLAN APPROVAL: 2007
SURVEY UNDER: 2000 New
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: One story, Type 11 (111)
SMOKE COMPARTMENTS: Three
COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM
FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)
EMERGENCY POWER: Type II Diesel generator

A life safety code survey was initiated and concluded on 09/26/13. 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 in substantial compliance with the Requirements for Participation for Medicare and Medicaid.

Deficiencies were cited with the highest deficiency identified at "E" level.

K 076 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards

K 000

The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and State law.

K076

K-076
Continued on next page.....

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 10/18/2013
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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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K 076 Continued From page 1 for Health Care Facilities. K076

- (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.
- (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one (1) of three (3) smoke compartments, staff and approximately twenty six (26) residents. The facility has the capacity for 64 beds with a census of 50 the day of survey

The findings include:

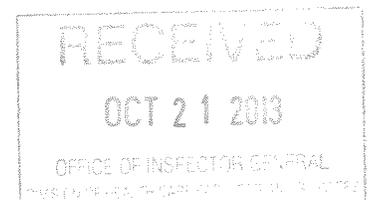
Observations during the Life Safety Code tour, on 09/26/13 at 10:05 AM, with the Director of Maintenance (DOM), sixteen (16) E size oxygen cylinder tanks were observed to be stored in the oxygen storage room. These tanks were within five (5) ft. of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cu. ft. must be kept five (5) ft. from combustibles.

Interview with the DOM, on 09/26/13 at 10:05 AM, revealed he could not keep staff from storing over twelve (12) cylinders in this room.

Quantities 300 cu. ft. (12 E sized cylinders) and

1. 8 of the cylinders were immediately relocated to a second storage location and secured in appropriate stands. This was performed by the Director of Maintenance September 26, 2013.
2. Due to the nature of the deficient practice it was determined by the Inter Disciplinary Team (IDT) consisting of a blend of Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, Medical Records Nurse (MRN), Activities Director (AD), Social Services Director (SSD), Director of Maintenance (DM), and Director of Housekeeping (DH), that all residents had the potential to be effected by the deficient practice.

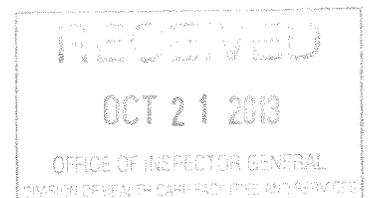
K-076 Continued next page...



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NAME OF PROVIDER OR SUPPLIER THE VILLAGE OF LEBANON II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 105 VILLAGE WAY LEBANON, KY 40033	
(X4) 10 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)
	<p>K 076 Continued From page 2</p> <p>less may follow the requirements of S&C-07-10. Reference: S&C-07-10 Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse ' s station or in a corridor of a healthcare facility. This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an " operational supply " and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in " crash carts " and in use on wheelchairs or gurneys. The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room. Reference: NFPA 99 1999 edition</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible</p>	<p>K076</p> <p>3. A safety audit was developed to identify any potential safety issues throughout the facility. The audit identifies safety issues in the facility including the appropriate storage of oxygen cylinders and other potentially hazardous materials and gases. The audit is to be performed 1 x week x 4 weeks, then bi weekly for one month (Longer if 100% compliance is not maintained). This will be performed by the Director of Maintenance or Designee, beginning September 26, 2013. Any equipment, oxygen cylinders or other potential hazards will be removed immediately and reported to administrator for oversight and direction. . (See Exhibit #4: Safety audit/Inspection).</p> <p>K-076 Continued on next page.....</p>	(X5) COMPLETION DATE



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K 076	Continued From page 3 construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of "h hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K076	K-076 Continued..... 4. Safety monitoring for specific areas including oxygen storage were added to the maintenance safety checks to ensure that the number of tanks stored throughout the facility do not exceed maximum storage of (300 ft3). The monitor will be reported monthly to the Quality Assurance Committee for oversight and direction. . (See Exhibit #4: Safety audit/Inspection). 5. Date Completed
			10/1/13

