

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

PRINTED: 09/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: t85253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2013
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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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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 An off site revisit was conducted which determined the the facility is deemed to be in compliance on 09/11/13 as alleged in the acceptable POC.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 CARTER NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143		
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F 000	INITIAL COMMENTS A Standard Recertification Survey was Initiated on 07/30/13 and concluded on 08/01/13. Deficiencies were cited with the highest scope and severity cited at an "E".	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for two (2) of twenty-three (23) sampled residents (Residents #4 and #7) and one (1) Unsampled resident, Unsampled Resident B. Observations during initial tour on 07/30/12 and observations on 07/31/13 revealed Residents #4, #7 and Unsampled Resident B, failed to have the indwelling catheter bag covered as outlined in facility policy. The findings include: Review of the facility's "Catheters/Urinary/Drainage Bag Covers" policy, effective date November 01/2011, revealed that unless a "fig leaf" drainage system (a drainage	F 241			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Louise Brown TITLE: CDI Director (X6) DATE: 8/22/2013

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days from 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 accreditation participation.

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F 000 INITIAL COMMENTS

A Standard Recertification Survey was initiated on 07/30/13 and concluded on 08/01/13. Deficiencies were cited with the highest scope and severity cited at an "E".

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for two (2) of twenty-three (23) sampled residents (Residents #4 and #7) and one (1) Unsampled resident, Unsampled Resident B. Observations during initial tour on 07/30/12 and observations on 07/31/13 revealed Residents #4, #7 and Unsampled Resident B, failed to have the indwelling catheter bag covered as outlined in facility policy.

The findings include:

Review of the facility's "Catheters/Urinary/Drainage Bag Covers" policy, effective date November 01/2011, revealed that unless a "fig leaf" drainage system (a drainage

F 000 To the best of my knowledge and belief, as an agent of Carter Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.

F 241 Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.

It is the policy of Carter Nursing and Rehabilitation Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

The catheter bag for resident #4 and #7 were placed in a cover by the charge nurse on 8/1/13.

The foley catheter for unsampled resident B had been removed by the charge nurse on 7/30/13 (after surveyor initial tour) as ordered by the physician.

09/11/2013

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F 241 Continued From page 1
bag system with a cover already in place), a drainage bag cover will be used at all times to provide dignity and privacy for the resident.

1. Review of Resident #4 Clinical Record revealed the facility admitted Resident #4 on 06/04/13 with diagnoses which included Urinary Retention, Low Back Pressure Ulcer and Altered Mental Status.

Observation, on 07/30/13 at 5:35 PM, revealed Resident #4's catheter bag was not covered with a privacy bag per facility policy.

2. Review of Resident #7's Clinical Record revealed the facility admitted Resident #7 on 10/26/12 with diagnoses which included Urinary Retention, Colostomy, Depression and Diabetes Mellitus Type II.

Observation, on 07/30/13 at 3:17 PM, revealed Resident #7's catheter bag was not covered with a privacy bag per facility policy. Further observation, on 07/31/13 at 9:13 AM, revealed Resident #7's catheter bag was without a privacy cover.

3. Record review revealed revealed Unsampled Resident B was admitted to the facility on 07/29/13 with diagnoses of Chronic Respiratory Failure, Staph Pneumonia, Anxiety, Congestive Heart Failure, Chronic Airway Obstruction.

Observation on initial tour, on 07/30/13 at 11:30 AM, revealed Unsampled Resident B had a bedside drainage bag attached to the bed frame facing the doorway without a dignity bag covering the drainage bag, the resident's door was open and the bedside drainage bag was visible from

F 241 All residents utilizing a foley catheter were visually reviewed by the ADON and RN Supervisors on 8/15/13 to ensure that all foley catheter bags had privacy covers in place. Additionally, a visual tour of the facility and all residents was conducted by the Administrator, DON and ADON on 8/1/13 by to ensure that no other issues were identified that would infringe on a resident's dignity.

All staff received education by the Staff Development Coordinator (SDC) by 9/9/13 regarding the importance of promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Specific emphasis was placed on ensuring that foley catheter bags were contained in a cover unless a fig bag type bag was in use.

Utilizing daily compliance rounds, the Administrator, DON, ADON, and/or RN Supervisors will audit care daily (Monday-Friday) for four weeks to ensure that residents are treated, and care is delivered, in a manner that recognize s each resident's dignity and respect in full recognition of his/her individuality. Any identified issues will be immediately corrected. These audits will continue to be completed weekly for three months thereafter.

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F 241	Continued From page 2 the hallway. Interviews with State Registered Nursin Assistants (SRNA) #3 and #4, on 08/01/13 at 4:50 PM and 4:55 PM, revealed catheter bags were supposed to be covered to maintain the dignity of the resident. Interview with Registered Nurse (RN) #2, on 08/01/13 at 5:00 PM, revealed her expectation was for staff to adhere to facility policy and use privacy bag covers to maintain resident dignity.	F 241	The results of these audits will be forwarded to the monthly Continuous Quality Improvement (CQI) Committee for further monitoring and continued compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	It is the policy of Carter Nursing and Rehabilitation Center to recognize that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. Each resident shall have a comprehensive care plan developed within seven days after the completion of the comprehensive assessment and this plan will be periodically reviewed and revised by a team of qualified persons. The plan of care for resident #8 was revised by the MDSC on 8/1/13 to reflect the intervention s put in place after falls that occurred on 3/7/13 and 3/31/13. On 7/31/13, side rails were padded and a larger, thicker pad (mattress) was placed by the bed of resident #8 to prevent injury. The IDCPT reviewed the plan of care for resident #8 on 8/1/13 to ensure that all interventions were	09/11/2013

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F 280 Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure comprehensive plans of care were reviewed and revised as needed for two (2) of twenty-three (23) sampled residents (Residents #8 and #1).

The facility failed to revise Resident #8's plan of care to include interventions added after falls in March and April of 2013.

The facility failed to revise Resident #1's plan of care upon admission to the facility to reflect current problems and goals.

The findings include:

Review of the facility's policy titled, "Care Conference-Interdisciplinary", effective 12/01/10, revealed the facility would ensure coordination of the departmental services so common goals of the resident would be accomplished as efficiently as possible. The policy also stated the facility would ensure the comprehensive plans of care were implemented and maintained in a timely fashion. In addition, the policy stated the facility would ensure all needs, problems, goals and approaches were documented on the care plan.

1. Record review revealed the facility re-admitted Resident #8, on 10/29/12, with diagnoses which included Acute Respiratory Failure, Chronic Airway Obstruction, Rheumatoid Arthritis, Congestive Heart Failure, Dementia, Altered Mental Status, Anxiety, and Chronic Pain.

F 280 recorded on the plan of care.

The plan of care for resident #1 was revised by the Social Services Director by 8/1/13 to reflect the current, individualized psychosocial needs for the resident. The Social Services Director discontinued the plan of care for the previous admission on the same day.

The IDCPT will review the plan of care for each resident by 9/10/13 to ensure that all care plans are reflective of the current assessment and current needs of each resident and that any additional interventions have been added to the plan of care as needed.

The DON provided additional education to the IDCPT on 8/23/13 regarding the importance of adding new interventions to the plan of care as changes occur. The Administrator provided one on one education to the Social Services Director on 8/1/13 regarding the importance of developing a plan of care for all residents that is reflective of the current needs of the resident; also, that the use of previous care plans from prior admissions is unacceptable. The DON or ADON will review at least five care plans per week for four weeks, and weekly thereafter for three months, to ensure that each plan of care is reflective of the resident's current needs and that interventions have been added/changed as the resident condition changes or incidents occur.

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F 280	Continued From page 4 Review of Resident #8's quarterly Minimum Data Set (MDS) assessment, dated 07/23/13, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15). A BIMS score of seven (7) indicated the resident was severely cognitively impaired. Resident #8 was assessed, under the Functional Status section, to require the assistance of two staff members with transfers and was not steady when moving from a seated to standing position and surface to surface transfer. Review of Resident #8's Post Fall Risk Evaluations, dated 03/08/13, 04/01/13, and 04/03/13 revealed he/she was at high risk for falls. The intervention section of the post fall evaluation (which stated to document details of interventions initiated), dated 03/08/13, revealed the current plan of care was to be continued. The intervention section of the post fall evaluations (which stated to document details of interventions initiated), dated 04/01/13 and 04/03/13, referred the reader to see interventions listed on the potential for injury plan of care. Review of Resident #8's Comprehensive Plan of Care, initiated 09/08/07, revealed the resident was at risk for injury related to falls and a medical diagnosis of Severe Rheumatoid Arthritis. The goal of the plan of care was for Resident #8 to be free of injuries related to falls through the next review date. Interventions listed on the plan of care did not include transporting the resident to the dining room last or laying the resident down after supper. In addition, there was no evidence the care plan had been revised to include the falls and interventions added post falls on 03/07/13, 03/31/13, and 04/02/13.	F 280	The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.	

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F 280

Continued From page 5

Review of the facility's Resident Incident Report, dated 03/07/13, revealed Resident #8 was found sitting on the floor beside his/her wheelchair. According to the document, Resident #8 told staff members he/she wanted to go to bed. Review of the Resident Focus Meeting Form, dated 03/07/13, revealed an intervention of laying Resident #8 down after supper would be added.

Review of the facility's Resident Incident Report, dated 03/31/13, revealed Resident #8 pulled on the table in the dining room and slid from his/her wheelchair. Review of the Resident Focus Meeting Form, dated 03/31/13, revealed Resident #8 would be one of the last residents transported to the dining room, as an intervention to prevent falls.

Review of the facility's Resident Incident Report, dated 04/02/13, revealed Resident #8 was found beside his/her bed on a mat. According to the report the resident had abrasions to his/her right forehead and eye. The report also stated Resident #8 had told staff he/she had scrapped his/her head and eye on the bed-rail when he/she was attempting to get out of bed. Review of the Resident Focus Meeting Form, dated 04/02/13, revealed no evidence of interventions to be added to prevent further injury/falls.

Interview with Certified Nursing Assistant (CNA) #1, on 08/01/13 at 3:26 PM, revealed she reviewed the care plans to determine what the resident's care needs were. CNA #1 stated the care plan detailed what interventions were specific to each resident. CNA #1 reported she was aware Resident #8 was a fall risk, however she was unaware Resident #8 was to be taken to

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F 280 Continued From page 6
the dining room last and laid down after supper.

Interview with Licensed Practical Nurse (LPN) #1, on 08/01/13 at 3:22 PM, revealed the nurses looked at the care plans to determine what the residents' care needs were. LPN #1, reported the MDS nurses were responsible for updating the resident's plan of care.

Interview with the Assistant Director of Nursing (ADON), on 08/01/13 at 11:15 AM, revealed after Resident #8's fall, on 04/02/13, an intervention was not added to the plan of care. The ADON reported an intervention would now be added to pad Resident #8's side-rails and add a larger mattress to the floor on the right side of his/her bed. The ADON reported she expected the resident's plans of care to be updated as falls occur. The ADON reported Resident #8's care plans should have been updated to reflect interventions added after each fall.

Interview with MDS Coordinator #1, #2, and #3 as well as the MDS Specialist, on 08/01/13 at 3:32 PM, revealed care plans were to be updated on an ongoing basis. The MDS Coordinators revealed the procedure for ensuring care plans were updated included receiving copies of Physician's Orders and/or were verbally informed of nursing interventions to be added during stand-up meetings held daily. The MDS Coordinators reported falls were reviewed during the stand-up meetings held daily. During these meetings, the MDS Coordinators stated the team would discuss interventions to be added to the resident's plan of care. The MDS Coordinators were not sure why Resident #8's plan of care had not been continually revised to include the falls and interventions added, on 03/07/13, 03/31/13

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F 280 Continued From page 7 and 04/02/13. The MDS Coordinators stated after each fall an appropriate intervention should have been added to Resident #8's plan of care.

F 280

Interview with the Director of Nursing (DON), on 08/01/13 at 2:55 PM, revealed fall investigations were reviewed daily during morning report. The DON reported the resident falls were also discussed weekly in focus meetings. The DON reported the team discussed interventions to be added after each fall. The DON stated the MDS Coordinators were responsible for updating the care plans to reflect the interventions added. The DON reported an intervention should have been added after Resident #8's fall, on 04/02/13. Lastly, the DON reported she expected Resident #8's interventions added after falls, on 03/07/13 and 03/31/13 to be on his/her plan of care.

2. Review of the facilities position description for Social Services Director, (no date), revealed residents' progress and updates of care plans was a key responsibility for the Social Services Director.

Record review revealed the facility admitted Resident #1 on 07/03/13 with diagnoses which include Congestive Heart Failure, Aortic Aneurysm, Dementia, Depression, Anxiety, Chronic Kidney Disease, Pacemaker, and Chronic Back Pain.

Review of Resident #1's Admission Minimum Data Set (MDS), dated 07/15/13, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of thirteen (13). A BIMS score of thirteen (13) indicated the resident was cognitively intact.

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F 280 Continued From page 8

Review of Resident #1's Comprehensive Plan of Care, initiated 07/09/13, revealed the resident was having thoughts of being better off dead or harming self and asking staff for a gun to kill himself/herself. The goal of the plan of care was for Resident #1 to have no self harm and seek help when thoughts of suicide were present through the next review dated 12/28/13. Further review of the plan of care revealed, resident displayed verbally aggressive behavior during care. The goal of the plan of care was for Resident # 1 to have decreased epslodes of verbally aggressive behaviors by 12/28/12. Additional review of the plan of care, dated 07/23/12 revealed resident displays physically aggressive behavior. Goals were to have decreased episodes of physically aggressive behaviors and no self harm or harm to others by 12/28/12.

Record review revealed Resident #1's was originally admitted to the facility on 06/26/12 and discharged on 10/06/12 to home.

Interview with the Social Services Director, on 07/31/13 at 2:30 PM, revealed the comprehensive plan of care was not accurate for Resident #1 and the resident did not exhibit any behaviors on the current admission of 07/03/13. The behaviors documented on the care plan were from Resident #1's previous admission, and she had not had time to update the care plan.

Interview with the Director of Nursing (DON), on 07/31/13 at 1:45 PM, revealed the comprehensive plan of care should have been updated on the current admission. The Social Service Director should make timely updates and

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F 280	Continued From page 9 there was ample opportunity to recognize and update the plan of care. Interview with the Administrator, on 08/1/13 at 3:45 PM, revealed the comprehensive plan of care should have been completed and revised upon the new admission. The Administrator stated the Social Services Director should have at least looked at the plan of care and not used one from an old admission.	F 280		
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview,	F 322	It is the policy of Carter Nursing and Rehabilitation to ensure that any resident who is fed by a naso-gastric or gastrostomy tube receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. The ADON removed and discarded all containers of tube feedings that had been spiked and were hanging unlabeled for resident #15, 16, and 18 on 7/30/13. The evening or midnight charge nurse (depending on start time for the resident) initiated a new container of tube feeding and new tubing on this same day. Containers were labeled by the charge nurse with resident name, date, rate and time by the charge nurse at the time the container was spiked and feeding initiated.	09/11/2013

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F 322 Continued From page 10
review of the facility's policy and review of manufacturer's guidelines, it was determined the facility failed to ensure residents fed by a gastrostomy tube received the appropriate treatment and services for three (3) of twenty-three (23) sampled residents and one (1) unsampled resident. Observations during initial tour revealed Resident #15, #16, #18 and Unsampled Resident A's gastrostomy tube feeding containers were spiked, but were not properly labeled.

The findings include:

Review of the facility's Census and Condition of Residents, dated 07/30/13, revealed six (6) out of one-hundred eleven (111) total residents received tube feedings.

Review of the facility's policy titled, "Gastric Tube Feedings", effective 12/01/10, revealed the facility would follow accepted practice guidelines related to the administration of gastric tube feedings.

Review of the facility's policy titled, "Gastric Feedings-Obtaining MD Order for and Prevention of Complications", effective 12/01/10, revealed the facility would label gastric feeding formulas with the resident's name, rate, date and time.

Review of the "Kangaroo 924 Eternal Feeding System" (tubing used to connect tube feeding) manufacture's guidelines, undated, revealed the tubing must be replaced every twenty-four (24) hours due to the risk of bacterial contamination and overall system accuracy. Continued review revealed each packet of tubing contained an adhesive label, which was to be placed on the tubing. The label contained areas to identify the

F 322 On 7/30/13, the ADON removed and discarded all bottles of tube feedings that had been spiked and were hanging on any other resident that receive nutrition via gastric tube. New bottles of tube feeding and new spike sets were initiated by the evening or midnight charge nurse (depending on start time for each resident) on the same day. All bottles were labeled by the charge nurse with the resident name, date, rate and time when the new bottle was spiked and feeding initiated.

The DON reviewed the infection control log on 8/2/13 to ensure that residents receiving tube feedings had not been identified to have exhibited any signs of gastrointestinal signs of an infection. Additionally, the ADON reviewed the nurse notes for the last 30 days on 8/5-6/13 for each resident receiving a tube feeding to determine that no signs of abdominal discomfort, diarrhea, vomiting, etc. had been noted in the resident record. No negative indicators were identified.

The SDC provided additional education to all licensed staff by 9/9/13 regarding the proper procedure for care and maintenance of a gastric feeding. This included the importance of infection control measures regarding spiking the tube feeding too early and labeling the bottles of tube feeding for each resident with the name, date, time and rate.

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F 322 Continued From page 11 resident, rate, time and date.

Review of the Jevity 1.2 Cal (tube feeding solution) manufacturer's guidelines revealed the container should not hang longer than forty-eight (48) hours after the initial connection. The manufacturer also stated a new feeding set (tubing) should be used with each new feeding.

Review of the TwoCal HN manufacturer's guidelines revealed the contained should not hang longer than forty-eight (48) hours after the initial connection. The manufacturer also stated a new feeding set (tubing) should be used with each new feeding.

1. Record review revealed the facility re-admitted Resident #15, on 05/21/13, with diagnoses which included Mental Disorder, Epilepsy, Benign Neoplasm of Brain, Aphasia, Depressive Disorder, and Pneumonia.

Review of Resident #15's Physician's Orders revealed an order, dated 05/21/13, for Jevity 1.2 Cal (tube feeding) at a rate of 60 cubic centimeters (cc) an hour via Gastrostomy tube, on at 1:00 PM, off at 9:00 AM.

Observation during initial tour, on 07/30/13 at 12:30 PM, revealed Resident #15's tube feeding solution, Jevity 1.2 Cal was hung on the bedside pole and was spiked with a feeding set (tubing). The feeding solution was not infusing, but had been spiked with tubing. Both the tube feeding solution and the feeding set (tubing) was not labeled with the resident's name, date, time or rate.

2. Record Review revealed the facility admitted

F 322 Each type of formula and specific hang times were reviewed with the licensed nursing staff. Literature was also made available for each brand of tube feeding utilized in the facility and placed at each nurse station for easy reference by the nursing staff.

The ADON or RN Supervisors will monitor tube feeding practices daily (Monday-Friday) for four weeks, and weekly thereafter for three months, to ensure that facility policies and accepted Standards of Practice are followed when administering gastric tube feeding. The results of these audits will be forward to the monthly CQI Committee meeting for further monitoring and continued compliance.

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F 322	<p>Continued From page 12</p> <p>Resident #16, on 09/23/09, with diagnoses which included Renal Failure, Pick's Disease, Dysphagia, Ankle/Foot Deformity and Cardiac Murmurs.</p> <p>Review of Resident #16's Physician's Orders revealed an order, dated 01/18/13, for Jevity 1.2 Cal (tube feeding) at a rate of 55 cc/hr via gastrostomy tube, on at 1:00 PM, off at 9:00 AM.</p> <p>Observation during initial tour, on 07/30/13 at 1:15 PM, revealed Resident #16's tube feeding solution, Jevity 1.2 Cal was hung on the bedside pole and was spiked with a feeding set (tubing). The feeding solution was not infusing, but had been spiked with tubing. Both the tube feeding solution and the feeding set (tubing) was not labeled with the resident's name, date, time or rate.</p> <p>3. Record review revealed the facility admitted Resident #18 on 12/13/12 with diagnoses which included Peripheral Vascular Disease, Atrial Fibrillation, Diabetes Type II, Arterial Disease, Orthopedic Aftercare and Rehabilitation.</p> <p>Observation during initial tour, on 07/30/13 at 11:45 AM, revealed Resident #18's tube feeding solution, Glucerna 1.2 was hung on the bedside pole and was spiked with a feeding set (tubing). The feeding solution was not infusing, but had been spiked with tubing. Both the tube feeding solution and the feeding set (tubing) was not labeled with the resident's name, date, time or rate.</p> <p>Review of Resident 18's Physician's Orders revealed an order, dated 05/29/13, for Glucerna (tube feeding) at a rate of 60cc (cubic</p>	F 322		
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F 322 Continued From page 13
centimeters) per hour via Gastrostomy tube, off at 6:00 AM and on at 6:00 PM.

4. Record review revealed the facility re-admitted Unsampld Resident A, on 01/15/08, with diagnoses which included Dementia, Acute Kidney Failure, Alzheimer's, Coronary Artery Anomaly, Hypertension, Anemia, Failure to Thrive, Depression and Arthropathy.

Review of Unsampld Resident A's Physician's Orders revealed an order, dated 12/14/12, for TwoCal (tube feeding) at a rate of 45 cc/hour via Gastrostomy tube, on at 1:00 PM, off at 9:00 AM.

Observation during initial tour, on 07/30/13 at 1:00 PM, revealed Unsampld Resident A's tube feeding solution, TwoCal was hung on the bedside pole and was spiked with a feeding set (tubing). The feeding solution was not infusing, but had been spiked with tubing. Both the tube feeding solution and the feeding set (tubing) was not labeled with the resident's name, date, time or rate.

Interview with Licensed Practical Nurse (LPN) #2, on 07/30/13 at 4:15 PM, revealed all tube feeding solutions should be labeled with the resident's name, date and time when spiked. LPN #2 stated if the solution was not labeled when spiked, there was no way to determine how long the bottle of solution had been hanging.

Interview with LPN #3, on 08/01/13 at 10:20 AM, revealed nurses were to label each bottle of tube feeding solution and the tubing set (tubing) with the resident's name, time, date, and rate when spiking the bottle/connecting the tubing. LPN #3 stated the tube feeding sets were only good to

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F 322	<p>Continued From page 14</p> <p>use for twenty-four (24) hours once connected to feeding. LPN #3 also stated tube feeding solutions could not be re-spiked with a different feeding set. Therefore, LPN #3 reported tube feeding solution should not hang longer than twenty-four (24) hours once connected to the tubing set.</p> <p>Interview with Registered Nurse (RN) #1 during initial tour, on 07/30/13 at 12:30 PM, revealed staff should label the tube feeding infusion set as well as the solution with the date and time they were hung/connected. RN #1 stated once connected, the feedings were only safe to use for twenty-four (24) hours.</p> <p>Interview with the Registered Dietician (RD), on 08/01/13 at 1:45 PM, revealed tube feeding solution/tubing should be labeled and dated when spiked/connected to tubing. The RD stated the tube feeding manufacturer's guidelines were to be followed, to ensure the quality of the product.</p> <p>Interview with the DON, on 08/01/13 at 2:55 PM, revealed it was the facility's policy to label tube feeding solutions and tubing sets with the resident's name, time, date and rate when the bottle is spiked/connected. The DON stated staff should follow the tube feeding solution and connection set manufacturer's guidelines.</p>	F 322		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>It is the policy of Carter Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	09/11/2013

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F 323 Continued From page 15

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free from accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents for one (1) of twenty-three (23) sampled residents. Resident #8 did not have interventions added after a fall, on 04/02/13 in which he/she fell from his/her bed and sustained a minor injury. In addition, Resident #8's plan of care was not revised to reflect interventions added after falls in March.

The findings include:

Review of the facility's policy titled, "Carter Fall Program", revised 08/01/12, revealed it was the policy of the facility to make resident safety a priority. According to the policy, the facility had a fall program to assist in identifying residents that were at risk for falls and to initiate interventions what out attempt to reduce the resident's risk. Under the identification section, the policy stated the facility would utilize the Fall Risk Assessment Form after the occurrence of a fall. After the occurrence of a fall, the policy stated the nurse would complete a fall investigation. In addition, the policy stated falls would be reviewed as part of a routine weekly focus meeting, in which all interventions would be evaluated and care plans

F 323 The plan of care for resident #8 was revised by the MDSC on 8/1/13 to reflect the interventions put in place after falls that occurred on 3/7/13 and 3/31/13. On 7/31/13, side rails were padded and a larger, thicker pad (mattress) was placed by the bed of resident #8 to prevent injury. The IDCPT reviewed the plan of care for resident #8 on 8/1/13 to ensure that all interventions were recorded on the plan of care. A fall risk assessment and an environmental assessment were completed for resident #8 by the MDSC on 8/19/13. The ADON interviewed and reviewed the plan of care with primary care givers (SRNAs, LPNs and RN Supervisors) on 8/1/13 to ensure that all preventive interventions were identified and recorded on the care plan for Resident #8. This resident has had no falls since 4/2/13.
A Fall Risk Assessment was completed for each resident in the facility by the DON, the ADON, and the MDSC's by 8/21/13. Any resident identified to be at risk for falls (score greater than 10) was assessed by the Focus Team on 8/22/13 to ensure that current interventions were recorded on the plan of care and the SRNA Care Card and that interventions were implemented at the bedside.
Additionally, residents at risk for falls were reviewed with direct care staff by the DON, the ADON and the SDC no later than 8/23/13 for additional preventive measures that may be needed.

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would be revised as indicated.

Record review revealed the facility re-admitted Resident #8, on 10/29/12, with diagnoses which included Acute Respiratory Failure, Chronic Airway Obstruction, Rheumatoid Arthritis, Congestive Heart Failure, Dementia, Altered Mental Status, Anxiety, and Chronic Pain.

Review of Resident #8's quarterly Minimum Data Set (MDS), dated 07/23/13, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMs) score of seven (7), this score indicated the resident was severely cognitively impaired. Under the Functional Status section, Resident #8 was assessed to require the assistance of two staff members with transfers and he/she was not steady when moving from a seated to standing position and surface to surface transfer.

Review of Post Fall Risk Evaluations, dated 03/08/13, 04/01/13, and 04/03/13 revealed Resident #8 was at high risk for falls. Resident #8 scored a twenty (20) or above on all three assessments; scores higher than ten (10) were considered high risk for falls. The intervention section of the post fall evaluation (which stated to document details of interventions initiated), dated 03/08/13, revealed Resident #8's current plan of care was to be continued. The intervention section of the post fall evaluations (which stated to document details of interventions initiated), dated 04/01/13 and 04/03/13, referred the reader to see the interventions listed on Resident #8's potential for injury plan of care.

Review of a plan of care, initiated 09/08/07, revealed Resident #8 was at risk for injury related

F 323 Any identified intervention will be recorded on the plan of care and the SRNA Care Card and communicated to the direct care staff by the charge nurse via verbal communication during shift to shift report and recorded by the DON, ADON or RN Supervisor on the SRNA daily shift report.

An environmental audit will be conducted by DON, ADON and SDC no later than 8/23/13 to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.

The Focus Team received additional education by the Administrator on 8/1/13 regarding the importance of communicating changes to the IDCPT and the direct care staff when new interventions are implemented. All staff will receive additional education by the Staff Development Coordinator no later than 9/9/13 regarding the importance of ensuring that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Nursing staff will receive additional education regarding the importance of reviewing the SRNA Care Cards and nursing report daily in order to be aware of updates and new interventions for those residents identified to be at risk for falls have a history of falls, or have had a recent fall/incident.

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F 323	Continued From page 17 to falls. The care plan stated the goal of the plan was for Resident #8 to be free of injuries related to falls through the next review date. Further review of the plan of care, revealed there was no evidence the care plan had been revised to include the falls and interventions added post falls, on 03/07/13, 03/31/13, and 04/02/13. Review of the facility's Resident Incident Report, dated 03/07/13, revealed Resident #8 was found sitting on the floor beside his/her wheelchair. The report also stated Resident #8 told staff members he/she wanted to go to bed. Review of the Resident Focus Meeting Form, dated 03/07/13, revealed an intervention would be added to lay Resident #8 down after supper. Review of the facility's Resident Incident Report, dated 03/31/13, revealed Resident #8 pulled herself/himself up from the dining room and slid from his/her wheelchair. Review of the Resident Focus Meeting Form, dated 03/31/13, revealed Resident #8 would be transported to the dining room last, as an intervention to prevent falls. Review of the facility's Resident Incident Report, dated 04/02/13, revealed Resident #8 was found beside his/her bed on a mat. The report stated Resident #8 had abrasions to his/her right forehead and eye. Review of the Resident Focus Meeting Form, dated 04/02/13, revealed there was no documented evidence of interventions to be added to Resident #8's plan of care to prevent further injury/falls. Interview with Certified Nursing Assistant (CNA) #1, on 08/01/13 at 3:26 PM, revealed she utilized the care plans to determine what the resident's care needs were. CNA #1 stated the care plan	F 323	The Administrator or DON will complete visual compliance rounds at least three times per week for four weeks, and weekly thereafter, to ensure that the environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Each incident report will continue to be reviewed daily (Monday-Friday) in nursing report by the Administrator and DON to ensure that appropriate interventions have been recorded and communicated to the IDCPT and direct care staff for implementation. The Administrator or DON will also follow up on at least five incident reports per week for four weeks, and weekly thereafter, to ensure that all interventions have been recorded and implemented as directed. All audits and reviews will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.		

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F 323 Continued From page 18
detailed what interventions were specific to each resident. CNA #1 reported she was aware Resident #8 was a fall risk. Yet, CNA #1 was not aware Resident #8 was to be taken to the dining room last and laid down after supper.

Interview with Licensed Practical Nurse (LPN) #1, on 08/01/13 at 3:22 PM, revealed the nurses referred to the care plans to determine what the resident's care needs were. LPN #1, reported the MDS nurses were responsible for updating the resident's plan of care on an ongoing basis.

Interview with the Assistant Director of Nursing (ADON), on 08/01/13 at 11:15 AM, revealed after Resident #8's fall, on 04/02/13, the facility failed to implement an intervention to his/her plan of care. The ADON reported Resident #8's care plans should have been updated to reflect interventions added to prevent further falls.

Interview with MDS Coordinator #1, #2, and #3 as well as the MDS Specialist, on 08/01/13 at 3:32 PM, revealed care plans were updated continually. The MDS Coordinators reported falls were reviewed during the stand-up meetings held daily. During these meetings, the MDS Coordinators stated the team would discuss interventions to be added to the resident's plan of care. The MDS Coordinators stated after each fall experienced by Resident #8, an appropriate intervention should have been implemented.

Interview with the Director of Nursing (DON), on 08/01/13 at 2:55 PM, revealed daily morning meetings were held in which falls from the previous day were reviewed. The DON reported resident falls and possible interventions were discussed weekly in focus meetings. The DON

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F 323	Continued From page 19 reported an intervention should have been added after Resident #8's fall, on 04/02/13. The DON also reported that she expected Resident #8's interventions added after falls, on 03/07/13 and 03/31/13 to be included in his/her plan of care.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policies and review of manufacturer's guidelines, it was determined the facility failed to store, prepare distribute and serve food under sanitary conditions. Observations during initial tour revealed strawberry shakes were stored in the refrigerator which were undated, cereal was stored unlabeled/undated in the dry storage area, a cup of yellow fluid was spilled in the refrigerator, two (2) expired packages of cottage cheese were stored in the refrigerator, and scoops were not properly stored. The findings include: Review of the facility's policy titled, "Sanitation", effective 08/01/12, revealed it was the policy of	F 371	It is the policy of Carter Nursing and Rehabilitation Center to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute, and serve food under sanitary conditions. The strawberry shakes, cereal, and cottage cheese were discarded by the dietary staff on 7/30/13 and 7/31/13. The cup of yellow fluid was discarded and the yellow fluid on the refrigerator shelf was cleaned by the dietary staff on 7/30/13. The scoops were re-washed by dietary staff on 7/30/13 and stored in a position where handles could be easily retrieved when needed for use. A sanitation audit was completed by the KY Team Leader and the Registered Dietician by 8/5/13 to ensure that no other sanitation or storage problems were identified. Any identified area was corrected immediately. All dietary staff received additional education by the Registered Dietician, KY Team Leader or the Dietary Manager no later than 8/27/13 regarding storage, preparation, and distribution of food items and the accepted sanitation practices in the dietary area.	09/11/2013

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F 371	<p>Continued From page 20</p> <p>the facility to maintain equipment, work surfaces, walls and floors in sanitary condition through daily ongoing procedures. The policy stated formal sanitation inspection in the food service department occurred on a frequent basis, along with informal sanitation inspections on a daily basis.</p> <p>1. Review of Manufacturer's Guidelines, dated 05/03/07 for Sysco Imperial Frozen Shakes revealed once thawed, the shakes must be used within fourteen (14) days. The Manufacturer advised to label the carton or case when the carton was placed in the refrigerator to thaw.</p> <p>Review of the facility's policy titled, "Refrigerated Storage", effective 06/01/13, revealed all foods would be properly wrapped and/or stored in a sealed container and dated and labeled. The policy stated food would be discarded within the appropriate shelf life.</p> <p>Observation of refrigerator #3 in the kitchen, on 07/30/13 at 11:55 AM, revealed the right bottom drawer was full of thawed Sysco strawberry shakes. All of the shakes were in cartons that had an area to write a thaw date. However, observation revealed none of the shakes contained a thaw date.</p> <p>Another observation of refrigerator #3, on 07/31/13 at 9:25 AM, revealed the facility continued to store eleven (11) thawed Sysco strawberry shakes in the bottom right drawer. All eleven (11) of the shakes were undated.</p> <p>Interview with Dietary Assistant #1, on 07/31/13 at 9:47 AM, revealed the Sysco strawberry shakes should be labeled by staff when they were placed</p>	F 371	<p>The Dietary Manager will conduct sanitation audits at least two times per week for four weeks, and weekly thereafter, to ensure that food is stored, prepared, distributed and served under sanitary conditions. The Registered Dietician will complete sanitation audits at least monthly. Any issues identified will be immediately corrected. The results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>		

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F 371	<p>Continued From page 21</p> <p>in the refrigerator to thaw. Dietary Assistant #1 stated all staff preparing snacks should check to ensure the shakes were dated.</p> <p>Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed staff should follow carton directions when labeling/storing items. She also stated staff should have labeled the strawberry shakes with a thaw date to ensure product the recommended use by dates were followed.</p> <p>Interview with the Registered Dietician (RD) during the initial kitchen tour, on 07/30/13 at 11:55 AM, revealed she expected staff to date the supplemental Sysco strawberry shakes when they were placed in the refrigerator to thaw. The RD stated it was important to place the thaw date on the shakes, so staff were aware how long the product could be used.</p> <p>2. Review of the facility's policy titled, "Dry Storage", effective 08/01/12, revealed it was the policy of the facility to store, prepare and serve food that is stored in accordance with federal, state and local sanitary codes. The policy stated foods would be labeled as to content and dated.</p> <p>Observation during the initial kitchen tour, on 07/30/13 at 11:35 AM, revealed there were seven (7) trays of cereal in the dry storage area which had been pre-scooped in bowls. The seven (7) trays of bowled cereal were covered; however, the bowls were not labeled or dated.</p> <p>Interview with Dietary Assistant #1, on 07/31/13 at 9:47 AM, revealed it was common practice for the dietary department to pre-scoop cereal in individual bowls, which was to be used the next</p>	F 371		
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day. Dietary Assistant #1 stated the bowls and/or trays of pre-scooped cereal should have been dated with the date which the item was prepared; as well as a use by date.

Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed staff should label prepared food in the dry storage area with the date the food was prepared. The Team Leader for Kentucky/Certified Dietary Manager stated it was important to label pre-prepared items to ensure items were used within acceptable use by dates.

Interview with the Registered Dietician (RD) during the initial tour, on 07/30/13 at 11:35 AM, revealed the bowls of cereal stored in dry storage should have been labeled when they were pre-scooped. The RD stated It was important to label the cereal, so all staff would know how long the product was good for use.

3. Review of the facility's policy titled, "Refrigerated Storage", effective 06/01/13, revealed all foods would be properly wrapped and/or stored in a sealed container and dated and labeled. The policy stated food would be discarded within the appropriate shelf life.

Review of the facility's policy titled, "Space and Equipment", effective 08/01/12, revealed it was the policy of the facility to provide a safe and sanitary provision of dietary services to the residents of the facility. Further review of the policy revealed all foods would be stored to protect from spoilage and contamination. In addition, all kitchen utensils would be stored in a sanitary manner to prevent contamination.

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F 371	<p>Continued From page 23</p> <p>Observation during the initial kitchen tour, on 07/30/13 at 11:55 AM, revealed the kitchen refrigerator #3 contained a cup of thick yellow substance which was not properly sealed and had spilled onto the shelf. A white towel at the base of the third shelf was also stained with a yellow substance. The cup of yellow substance was not labeled or dated.</p> <p>Another observation, on 07/31/13 at 9:25 AM, revealed refrigerator #3 continued to contain a white towel at the base of the third shelf which was soiled with a yellow substance.</p> <p>Interview with Dietary Assistant #1, on 07/31/13 at 9:47 AM, revealed the refrigerators were cleaned on evening shift daily. Dietary Assistant #1 stated all staff were responsible to clean spills in the refrigerator. Dietary Assistant #1 also stated the yellow substance in the refrigerator should have been properly covered and labeled.</p> <p>Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed spills in the refrigerator should be cleaned by the first person that made the observation. She also stated all items in the refrigerator should be labeled/dated. The Corporate Team Leader for Kentucky/Certified Dietary Manager stated it was important to properly seal/label food items and to keep the refrigerator clean to prevent cross contamination.</p> <p>Interview with the Registered Dietician (RD), on 07/30/13 at 11:55 AM, revealed the cup of yellow substance found in refrigerator #3 needed to be discarded. The RD stated items placed in the refrigerator should be sealed and dated.</p>	F 371			

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F 371	<p>Continued From page 24</p> <p>4. Review of the facility's policy titled, "Refrigerated Storage", effective 06/01/13, revealed all foods would be properly wrapped and/or stored in a sealed container and dated and labeled. The policy stated food would be discarded within the appropriate shelf life.</p> <p>Observation during the initial kitchen tour, on 07/30/13 at 11:40 AM, revealed refrigerator #2 contained two packages of cottage cheese which expired, on 07/29/13.</p> <p>Interview with Dietary Assistant #1, on 07/31/13 at 9:47 AM, revealed all items should be used by or discarded prior to expiration. Dietary Assistant #1 stated all kitchen staff were responsible to ensure items in the refrigerator were not expired.</p> <p>Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed all staff were responsible for checking to ensure all items were stored within the expiration date. The Corporate Team Leader for Kentucky/Certified Dietary Manager, stated items should be discarded or used by the expiration date on the product.</p> <p>5. Review of the facility's policy titled, "Space and Equipment", effective 08/01/12, revealed it was the policy of the facility to provide a safe and sanitary provision of dietary services to the residents of the facility. Further review of the policy revealed all foods would be stored to protect from spoilage and contamination. In addition, all kitchen utensils would be stored in a sanitary manner to prevent contamination.</p> <p>Observation during the initial kitchen tour, on 07/30/13 at 12:00 PM, revealed clean scoops</p>	F 371			

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F 371	<p>Continued From page 25</p> <p>were stored in a wire basket on the wall by the sink. The scoops inside this basket were stored with their handles in opposite directions.</p> <p>Interview with Dietary Assistant #1, on 07/31/13 at 9:47 AM, revealed scoops should be stored with the handles in the same direction. Dietary Assistant #1 stated proper scoop storage was important to prevent contamination of the food surface of the handle.</p> <p>Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed staff should store scoops so they can be reached without touching the food surface of another due to infection control reasons.</p> <p>Interview with the Registered Dietician (RD) during initial tour, on 07/30/13 at 12:00 PM, revealed scoops should be stored with the handles all facing the same direction. The Registered Dietician stated the scoops should be stored in the same direction to prevent touching of the part of the scoop used to serve food.</p>	F 371		
F 465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 465	<p>It is the policy of Carter Nursing and Rehabilitation Center that the facility be maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>The Maintenance Director removed the green/black substance from the walls, baseboards and pipes and corrected the water leak on 7/31/13.</p> <p>The task of deep cleaning the dish room will be added to the task list by the Dietary Manager by 8/27/13.</p>	09/11/2013

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by:
Based on observation, interview, review of the facility's policy and review of the facility's forms, it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Observations revealed a green/black substance present on the walls, baseboards, pipes and the under surface of the metal counter in the dish room. In addition, there was a leak noted from a pipe under the garbage disposal.

The findings include:

Review of the facility's policy titled, "Space and Equipment", effective 08/01/12, revealed lighting, ventilation and humidity would be controlled to prevent moisture condensation and the growth of molds.

Review of the facility's policy titled, "Sanitation", effective 08/01/12, revealed it was the policy of the facility to maintain equipment, work surfaces, walls and floors in sanitary condition through daily ongoing procedures. The policy stated formal sanitation inspection in the food service department occurred on a frequent basis, along with informal sanitation inspections on a daily basis.

Review of the facility's policy titled, "Equipment Cleaning Schedules", effective 08/01/12, revealed it was the policy of the facility to assign cleaning schedules on a daily, weekly and monthly basis. The policy indicated the walls were to be cleaned monthly and weekly as needed.

Review of the "August Monthly Cleaning List" form, undated, revealed staff were to sweep/mop

F 465 All staff will receive education by the Staff Development Director, the Housekeeping Supervisor, the Dietary Manager, or the Maintenance Supervisor no later than 9/1/13 regarding the importance of maintaining the facility in a manner that provides a safe, functional, sanitary and comfortable environment for residents, staff and the public. Additional education will include the use of maintenance requisition slips in order to notify maintenance of needed repairs and track the correction of identified issues.

The Maintenance Director and the Housekeeping Supervisor will complete an environmental audit by 9/1/13 to ensure that the facility is maintained in such a manner so as to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Any identified issues will be corrected as identified.

The Administrator, Maintenance Supervisor, or the Housekeeping Supervisor will complete environmental rounds at least three times per week for four weeks, and weekly thereafter, to identify issues that may need corrected in order to maintain a safe, functional, sanitary and comfortable environment.

The results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.

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dish room daily. Review of other task revealed the dish room shelves were to be cleaned once monthly. However, continued review of the cleaning schedule revealed no assignments or task of deep cleaning or cleaning of the walls or under countertops in dish room.

Review of the facility's form "Sanitation Audit", dated 06/19/13, revealed the Registered Dietician (RD) had performed a sanitation audit of the kitchen. Review of the form revealed the garbage disposal, dishwasher and dish room areas were not addressed/listed on the audit.

Interview with the RD, on 07/30/13 at 11:25 AM, revealed she had recently been at the facility eight (8) to sixteen (16) hours per week due to the current absence of the Dietary Manager.

Interview with the Corporate Team Leader for Kentucky/Certified Dietary Manager, on 07/31/13 at 9:28 AM, revealed she was to begin visiting the facility on a regular basis due to the absence of the Dietary Manager.

Observation of the dish room, on 07/31/13 at 4:25 PM, revealed a green/black wet substance present on the underside of the metal counter by the garbage disposal/dishwasher.

Further observation of the dish room with the Maintenance Director (using a flashlight) present, on 07/31/13 at 4:35 PM, revealed water was leaking from a pipe under the garbage disposal. A green/black wet substance was observed on the pipe which was leaking as well as the wall under the garbage disposal, the under surface of the metal counter and the baseboard between the garbage disposal and the dishwasher.

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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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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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Interview with Dietary Assistant #3, on 07/31/13 at 4:45 PM, revealed she was aware a grease like substance was present under the garbage disposal in the dish room. Dietary Assistant #3 stated she was unaware who was responsible to clean the dish room walls. Dietary Assistant #3 believed Maintenance had painted the area a year ago, but she reported she had never informed anyone of the substance on the wall and under the garbage disposal. Dietary Assistant #3 stated she was not aware of the leak under the garbage disposal. Continued interview with Dietary Assistant #3, on 08/01/13 at 2:03 PM, revealed she now believed the substance on the wall in the dish room was a result of food washing behind the counter.

Interview with Dietary Assistant #1, on 08/01/13 at 2:13 PM, revealed there was typically a monthly cleaning list posted. However, she reported a cleaning list was not posted for July due to the absence of the Dietary Manager. Dietary Assistant #1 stated second shift was primarily responsible for cleaning the dish room. Dietary Assistant #1 reported all of the heavy cleaning was conducted on second shift. Dietary Assistant #1 stated she had never noticed a substance on the wall/counter or baseboards in the dish room. Dietary Assistant #1 was also unaware of the leak under the garbage disposal.

Interview with Dietary Assistant #4, on 08/01/13 at 2:18 PM, revealed second shift was responsible for cleaning the items listed on Monthly Cleaning List. Dietary Assistant #4 stated she had noticed a greasy substance on the wall in the dish room three (3) to four (4) months ago. Dietary Assistant #4 stated she had verbally informed maintenance

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personnel, but she could not remember specifically whom. Dietary Assistant #4 stated she thought the area had been cleaned by maintenance and was no longer an issue.

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Interview with the Maintenance Director, on 07/31/13 at 4:35 PM, revealed he was aware of the green/black substance on the wall under the garbage disposal. The Maintenance Director stated he believed the substance on the wall was grease. The Maintenance Director was not sure how often the dish room and the garbage disposal area were cleaned. The Maintenance Director reported he was unaware of the leak under the garbage disposal. The Maintenance Director stated he had painted in the dish room in the past, but he could not remember when this occurred. The Maintenance Director reported kitchen staff (unaware of exactly who) had asked him a few weeks ago if he had something to clean the wall in the dish room. He reported that he told the kitchen staff he did not have anything to clean the area with. The Maintenance Director stated the kitchen staff had reported to him that the substance on the wall was grease. The Maintenance Director denied receiving a written request related to the substance on the walls/pipes and under the counter in the dish room. He also denied having received a maintenance request for the leak under the garbage disposal.

Interview with the RD, on 08/01/13 at 1:45 PM, revealed she was unaware of the substance in the dish room until she was informed by the surveyor. The RD reported dietary staff had not reported the substance on the wall or the leak in the dish room to her. The RD reported the dish room was to be cleaned nightly. The RD stated

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the substance on the walls, baseboards, pipes and the underside of the garbage disposal should not have been present in the dish room. Lastly, the RD reported if staff were aware of the substance on the wall in the dish room, they should have reported the issue to the maintenance department to ensure resident safety.

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Interview with the Administrator, on 07/31/13 at 4:55 PM, revealed he agreed there was a "slimy black" substance present in the dish room along the walls, baseboards, pipes and counter under the garbage disposal. The Administrator stated he was not exactly sure what the substance was, but he clearly stated it should not have been present.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1985 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One story Type III. Smoke Compartment: Five smoke compartments Fire Alarm: Complete fire alarm system. Panel upgraded in 2006. Sprinkler System: Complete automatic (dry/wet) sprinkler system. System installed in 1985. Generator: Type II</p> <p>A standard life safety code survey was conducted on 07/31/13. Carter Nursing and Rehabilitation Center was found not be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was one hundred twelve (112). The facility is licensed for one hundred twenty (120) beds.</p> <p>The Highest Scope and Severity deficiency was an "E" level.</p>	K 000	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted</p>	K 025	
REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Louise Loux RN, CQIP

CPD Director

8/22/2013

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1985 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One story Type III. Smoke Compartment: Five smoke compartments Fire Alarm: Complete fire alarm system. Panel upgraded in 2006. Sprinkler System: Complete automatic (dry/wet) sprinkler system. System installed in 1985. Generator: Type II A standard life safety code survey was conducted on 07/31/13. Carter Nursing and Rehabilitation Center was found not be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was one hundred twelve (112). The facility is licensed for one hundred twenty (120) beds. The Highest Scope and Severity deficiency was an "E" level.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025	It is the policy of Carter Nursing & Rehabilitation Center to ensure smoke barriers are properly maintained and no penetration exists.	09/11/2013

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

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K 025 Continued From page 1
heating, ventilating, and air conditioning systems.
19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, fifty two (52) residents, staff and visitors.

The findings include:

Observations, on 07/31/2013 at 12:40 PM, revealed the two (2) smoke barriers in the center hall had a total of five (5) penetrations. Penetrations in smoke barriers must be sealed with material equal or greater to the rating of the smoke barrier. The observations were confirmed with the Regional Maintenance Director.

Interview, on 07/31/2013 at 12:40 PM, with the Regional Maintenance Director, revealed the penetrations were from the installation of internet wiring. Further interview revealed all penetrations should be sealed.

The findings were confirmed with the Administrator at time of exit.

Reference: NFPA 101 (2000 edition)
8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment

K 025 The two smoke barriers in the facility center hall containing five penetrations were sealed by the facility maintenance supervisor and regional maintenance director on 7/31/2013. The regional maintenance supervisor and the facility maintenance supervisor completed an inspection of the facility smoke barriers to ensure there were no additional penetrations. There were no penetrations noted on the inspection. The facility maintenance supervisor and the maintenance assistance received re- education from the facility administrator on 8/19/2013 outlining the importance of assuring there are no smoke barrier penetrations. The education included inspection of barriers after 3rd party contractors completed work. Monthly for three months and quarterly thereafter the maintenance supervisor or designee will perform an inspection of the smoke barriers within the facility to ensure there are no penetrations. This inspection will be presented to the facility Continuous Quality Improvement Committee who meets monthly for additional monitoring and continued compliance.

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K 025	Continued From page 2 that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029	It is the policy of Carter Nursing & Rehabilitation Center to ensure hazardous areas within the facility are equipped with door self-closures.	09/11/2013	

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K 029	<p>Continued From page 3</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty six (26) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation and interview, on 07/31/2013 at 2:01 PM, revealed three (3) fuel fired water heaters located in a room next to the Living Room. Further observation revealed the room had two doors that were not equipped with self-closers. Rooms housing fuel fired water heaters must be equipped with self-closers on the doors. The observation was confirmed with the Regional Maintenance Director.</p> <p>Interview, on 07/31/2013 at 2:01 PM, revealed the facility had remodeled the area last year and had failed to install self-closers on the doors.</p>	K 029	<p>Door self-closures were installed on the mechanical rooms doors on 8/12/2013 by the regional maintenance director.</p> <p>The facility was inspected by the regional maintenance director and the facility administrator on 8/2/2013 to ensure all hazardous areas within the facility had door self-closures installed and were in proper working order.</p> <p>On 8/12/2013 the facility maintenance staff was re- educated by the regional maintenance director the importance of having door self-closures in place and functional in all hazardous areas within the facility.</p> <p>Monthly the facility maintenance supervisor or designee will check each hazardous are within the facility containing door self-closures to ensure the closures are in place and in proper working order. Results of these monthly inspections will be forwarded to the facility continuous quality improvement committee for additional monitoring and continued compliance.</p>		

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K 029 Continued From page 4
The findings were confirmed with the Administrator at time of exit.

Reference: NFPA 101 (2000 edition)
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
- (8) Laboratories employing flammable or combustible materials in quantities less than those that would be

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K 029 Continued From page 5 considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 029

K 062 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

K 062

It is the policy of Carter Nursing & Rehabilitation Center to ensure the facility sprinkler heads are maintained in proper working order. On 8/3/2013 the regional maintenance director and facility maintenance staff completed an inspection of all the sprinkler heads within and outside the facility. On or before 9/1/2013 the corroded sprinkler heads identified during the annual inspection and the facility inspection were replaced by a certified contractor. The facility maintenance staff received education by the facility administrator regarding the importance of visually inspecting the facility sprinkler heads and ensuring any that are corroded or appear to not be in proper working order are replaced.

09/11/2013

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty six (26) residents, staff and visitors.

The findings include:

Observation, on 07/31/2013 at 12:33 PM, revealed a total of seven (7) corroded sprinkler heads in the kitchen. Sprinkler heads that are corroded must be replaced. The observation was confirmed with the Maintenance Director.

Interview, on 07/31/2013 at 12:33 PM, with the Maintenance Director, revealed the facility had failed to identify the corroded sprinkler heads

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K 062 Continued From page 6 prior to the survey.

The findings were confirmed with the Administrator at the time of exit.

Reference NFPA 25 (1998 edition)

Refer 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.

Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.

K 062 Monthly for three months and quarterly thereafter the facility maintenance supervisor or designee with complete a visual inspection of the sprinkler heads located within and outside the facility to ensure they are not corroded and appear to be in proper working order.

Results of the visual inspections will be forwarded to the facility continuous quality improvement committee for additional monitoring and continued compliance.