

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



PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
|--|--|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 |
|--|--|

| (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) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
|--------------------|--|---------------|--|----------------------|

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#23476 was conducted on 07/14/15 through 07/17/15. KY#23476 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".
F 157 483.10(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 000

Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.

F 157

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

Corrective Measures for Resident(s) Identified In The Deficiency
[1] Resident #1 was assessed by the Licensed nurse on 07/18/15 for any signs or symptoms of bleeding.
[2] Registered Nurse #3 was educated by the Director of Nursing on 07/23/15 regarding notification of the physician with resident change in condition.

How Other Resident's Who May Be Affected By This Practice Were Identified
An audit will be completed by the Director of Nursing and Unit Managers to see if any other resident receiving Xarelto had any symptoms of bleeding not reported to their physician.

08/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angela M. [Signature]

TITLE
NHA

(X5) DATE
08/10/15

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.

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE |
| F 157 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to notify the physician for one (1) of three (3) sampled residents (Resident #1) related to coughing up blood several times during a shift.</p> <p>The findings include:</p> <p>Review of facility policy titled "Notification Requirements", dated 05/22/12, revealed the nurse should not hesitate to contact the physician at any time for a problem which in their judgement requires immediate attention. The nurse should assess actions already taken and document all attempts to notify physician.</p> <p>Record review revealed the facility admitted Resident #1 on 05/11/15 with diagnoses which included Congestive Heart Failure, Peripheral Vascular Disease, Atrial-Fibrillation, and Pacemaker. Review of the admission Minimum Data Set (MDS) assessment, dated 05/28/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of five (5) which indicated the resident was not interviewable. Further review revealed the resident required extensive assistance with activities of daily living.</p> <p>Review of Nursing Notes, dated 06/06/15 at 3:00 PM, revealed Resident #1 was coughing up blood several times during the shift and there was no documented evidence the physician was notified.</p> | F 157 | <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] Registered Nurse #3 was educated by the Director of Nursing on 07/23/15 regarding notifying the physician of any resident change in condition.</p> <p>[2] 100% of Licensed Nurses were educated beginning on 07/16/15 regarding the notification of the physician when a resident has a change in condition.</p> <p>[3] 100% of Licensed Nurses were educated beginning on 07/16/15 regarding documentation of resident change in condition on the 24 Hour Report book for follow up by the following shift.</p> <p>[4] The Director of Nursing or the Unit Manager will audit the 24 Hour Report book Monday through Friday for any changes in resident conditions and follow up on the condition changes during the Abbreviated Quality Assurance Meeting. On Mondays, any changes in resident conditions that occurred on Saturdays and Sundays will be discussed during the Abbreviated Quality Assurance Meeting.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Director of Nursing will be responsible for bringing the results of the 24 Hour Report book audit to the Quality Assurance Committee</p> <p>08/15/15</p> |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0381

| | | | | |
|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 157 | Continued From page 2 Review of the facility Twenty-four (24) Hour Report sheet, dated 06/06/15, revealed no evidence the physician was notified Resident #1 was coughing up blood several times during the shift. Attempts at interviewing Registered Nurse (RN) #3 who provided care on 06/06/15 on 07/16/15 at 10:08 AM and 10:52 AM were unsuccessful. Interviews on 07/16/15 with Registered Nurse (RN) #1 at 10:40 AM and and RN #2 at 10:45 AM, revealed if a resident was coughing up blood several times during the shift they would have expected the physician to be contacted. Interview with Director of Nursing (DON), on 07/15/15 at 2:30 PM, 07/16/15 at 11:40, and 07/17/15 at 12:00 PM, revealed if the notification of the physician was not charted then it was not done. She stated she would have notified the physician that Resident #1 was coughing up blood several times during the shift. The DON said she expected staff to follow the facility policy related to physician notification. Interview with Resident #1's Physician, on 07/16/15 at 10:58 AM, revealed he was not made aware of the resident coughing up blood on 06/06/15 and he should have been notified. | F 157 | [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Medical Records Director, Maintenance Director, Dietary Manager, Human Resources Director] monthly times three months. | 08/15/15 |
| F 252 SS=D | 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings | F 252 | F 252 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE/ENVIRONMENT <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> No residents identified in the deficiency <u>How Other Resident's Who May Be Affected By This Practice Were Identified</u> No residents identified. | |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 252 | Continued From page 3 to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure a safe environment related to the storage of medications without staff supervision. Insulin, syringes, and glucagon pen was left on a medication cart without staff supervision. The findings include: Review of a facility policy titled, " Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", dated 01/2013, revealed the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Observation on 07/14/15 at 9:27 PM revealed upon arrival a visitor opened the door to the facility for the surveyor and the medication carts were on the hall with no staff in sight. Further observation revealed there were nine (9) insulin vials, one (1) syringe, and a glucagon pen on top of the medication cart Interview with Registered Nurse (RN) #4, on 07/14/15 at 11:00 PM, revealed she had just walked away from the medication cart. Interview with Unit Manager #3, on 07/15/15 at 10:35 AM, revealed the insulin, glucagon pen and syringe should be locked up if the nurse is not around. | F 252 | <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] Audit was conducted on 07/17/15 by the Director of Nursing to ensure there were no medications sitting out unsecured. [2] Registered Nurse #4 was educated by the Director of Nursing on 07/17/15 regarding not leaving medications sitting out unsecured. [3] 100% of the Licensed Nurses were educated beginning on 07/23/15 regarding not leaving medications sitting on top of the medication carts unsecured. [4] Audits being conducted by the Unit Managers or Director of Nursing to check for any medications sitting out unsecured daily times five days; three times a week times three weeks; one time week time three weeks; every other week times three weeks; monthly times three months. <u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Medical Records Director, Maintenance Director, Dietary Manager, Human Resources Director] | 08/15/15 |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 252 | Continued From page 4 | F 252 | monthly times three months. | |
| F 282 SS=D | <p>Interview with the Director of Nursing (DON), on 07/14/15 at 11:25 PM and on 07/16/15 at 11:40 AM, revealed the insulin, syringe and glucagon pen should be locked in the medication cart if the nurse has to leave the cart. She stated she expected the staff to follow the facility policy.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to implement the care plan for one (1) of three (3) residents (Resident #1). Resident #1 was care planned to evaluate for s/s of bleeding to include hemoptysis (blood in sputum); however, staff failed to notify the physician when the resident coughed up blood several times during a shift.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Interim Care Plans Clinical Practice Guidelines", dated 01/14/10, revealed the nurse was responsible for initiating the initial care plan for identified problems and should include the date care was initiated, identified problems/concerns, short term measurable goals, approaches/interventions, the discipline responsible, and evaluation with implementation of the initial care plan</p> | F 282 | <p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency</u> [1] Resident #1 was assessed by the Licensed nurse on 07/18/15 for any signs or symptoms of bleeding.</p> <p><u>How Other Resident's Who May Be Affected By This Practice Were Identified</u> An audit was conducted on 08/06/15 by the Director of Nursing and Unit Managers to make sure residents receiving an anti-coagulant such as Xarelto or Coumadin, had not had any signs/symptoms of bleeding that had not been reported to the physician.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] Registered Nurse #3 was educated by the Director of Nursing on 07/23/15 regarding following resident care plans when providing care. [2] 100% of the Licensed Nurses were educated beginning on 07/23/15 regarding following the residents' care</p> | 08/15/15 |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|---|--|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 282 | Continued From page 5 communicated to appropriate staff. The resident's response to the care plan interventions will be monitored, and implementation will be documented. Review of facility policy titled, " Initial Care Plans", last revised 01/14/10, revealed staff should provide an initial care plan to meet the emerging needs of residents upon admission and with condition changes during his/her stay at the facility. Record review revealed the facility admitted Resident #1 on 05/11/15 with diagnoses which included Congestive Heart Failure, Peripheral Vascular Disease, Atrial-Fibrillation, and Pacemaker. Review of the admission Minimum Data Set (MDS) assessment, dated 05/28/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of five (5) which indicated the resident was not interviewable. Further review revealed the resident required extensive assistance with activities of daily living. Review of Resident #1's Comprehensive Care Plan for anticoagulant therapy, dated 05/11/15, revealed Resident #1 was on an anticoagulant (Xarelto) with interventions dated 06/04/15 to evaluate for s/s of bleeding-hematuria, rectal bleeding, hemoptysis, excessive bruising, melena, petechial, and black stools. Review of Nursing Notes, dated 06/06/15 at 3:00 PM, revealed Resident #1 was coughing up blood several times during the shift, with no notification made to the physician by RN #3. | F 282 | plans when providing care. [3] Residents receiving an anti-coagulant such as Xarelto or Coumadin had their anti-coagulant care plans placed with their Medication Administration Record for a quick reference on 08/06/15 by the Unit Managers. [4] 100% of residents receiving an anti-coagulant such as Xarelto or Coumadin were audited on 08/06/15 by the Unit Managers and Director of Nursing to make sure each of the residents are being observed every shift by the Licensed Nurse for signs and symptoms of bleeding. [5] Follow up audit will be conducted by the Unit Managers monthly times two months to make sure all residents receiving an anti-coagulant such as Xarelto or Coumadin are being observed for signs and symptoms of bleeding every shift. <u>Monitoring Measures To Maintain On-Going Compliance</u> The Director of Nursing will be responsible for bringing the results of the audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Medical Records Director, Maintenance Director, Dietary | 08/15/15 | |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 282 | Continued From page 6 Attempts to interview Registered Nurse (RN) #3 (who was responsible for caring for Resident #1 on 06/08/15), on 07/16/15 at 10:08 AM and 10:50 AM were unsuccessful. Interview with Licensed Practical Nurse (LPN) #1, on 07/16/15 at 2:41 PM, revealed in order for staff to follow the care plan related to signs and symptoms of bleeding the nurse would have to evaluate the bleeding and notify the physician of the signs and symptoms of bleeding. Interview with the Unit Manager, on 07/16/15 at 11:15 AM, revealed if the resident's care plan stated to watch for hemoptysis because the resident was on anticoagulant therapy, she would expect the nurse to notify the physician if blood was observed coming from the mouth whether it was care planned or not. Interview with the Director of Nursing (DON), on 07/16/15 at 11:40 AM, revealed for staff to follow Resident #1's anticoagulant care plan she would expect staff to assess the resident, notify the physician and document this in the resident's record. | F 282 | Manager, Human Resources Director] monthly times three months | 08/15/15 |
| F 356 SS=D | 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. | F 356 | F 356 483.30(e) POSTED NURSE STAFFING INFORMATION <u>Corrective Measures for Resident(s) Identified In The Deficiency</u> No residents identified in the deficiency <u>How Other Resident's Who May Be Affected By This Practice Were Identified</u> No residents identified in the deficiency. | |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42446 | |
| (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 356 | <p>Continued From page 7</p> <ul style="list-style-type: none"> - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to post nursing staff data to include licensed staffing information in a prominent place.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Nursing Services-Staffing", dated 01/01/07, revealed schedule for all nursing staff will be posted in a designated area. Assignments of nursing staff will be accessible as indicated by Individual State requirements.</p> | F 356 | <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] The Staffing Scheduling Coordinator was educated by the Director of Nursing on 07/27/15 regarding keeping the Nursing Census Report placed in the holder that is located in a public area at all times Monday through Friday.</p> <p>[2] The Licensed Nurse will be responsible for placing the Nursing Census Report in its holder in a public area of the facility on Saturdays and Sundays.</p> <p>[3] An audit will be conducted by the Director of Nursing or the Unit Managers to make sure the Nursing Census Report is in its holder in a public area of the facility daily times seven days; three times a week times one week; one time a week times one week; every other week times one.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance</u></p> <p>The Director of Nursing will be responsible for bringing the results of the audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Medical Records Director, Maintenance Director, Dietary Manager, Human Resources Director] monthly times one month.</p> |
| | | | 08/15/15 |

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445 | |
| (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 356 | <p>Continued From page 8</p> <p>Observation on 07/14/15 at 9:30 PM and 11:30 PM, revealed the facility failed to post staffing.</p> <p>Interview with Registered Nurse (RN) #4, on 07/14/15 at 11:00 PM, revealed staffing information was not posted. She stated she had seen it posted before but did not know who was responsible for posting the staffing information.</p> <p>Interview with the present Scheduler, on 07/16/15 at 8:30 AM, revealed she was responsible for posting licensed staffing information in a prominent place; but did not know it was supposed to be posted at all times.</p> <p>Interview with the former Scheduler, on 07/16/15 at 10:52 AM, revealed staffing was supposed to be posted and the new scheduler had been taught to post the staff information daily.</p> <p>Interview with the Unit Manager #1, on 07/14/15 at 11:05 PM and on 07/16/15 at 11:15 AM, revealed the Scheduler prints out the staffing sheet and posts it in the morning and takes it down when she leaves and has done it that way for three (3) years. UM #1 stated she was not aware of the requirement for staffing to be posted at all times.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 11:40 AM, revealed staffing was supposed to be posted at all times.</p> | F 356 | |
| (X5) COMPLETION DATE | | | |