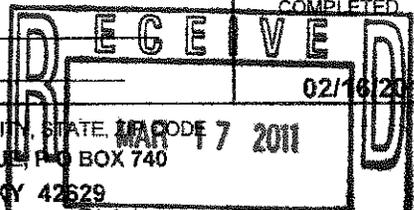


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2011
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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE P.O. BOX 740 JAMESTOWN, KY 42629
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of twenty-three sampled residents were free from physical restraints. The facility failed to assess and attempt to eliminate/reduce restraints for resident #12 and resident #20.</p> <p>The findings include:</p> <p>A review of the facility's "Restraint Policy," no date given, revealed the use of restraints for discipline or convenience is prohibited and restraints are only to be utilized to treat a medical symptom. In addition, assessment and care planning were required prior to use of restraints.</p> <p>A review of the medical record for resident #12 revealed the resident was admitted to the facility on December 27, 2005, with diagnoses of Senile Dementia, Alzheimer's Disease, Diabetes, Hypertension, Aphasia, and Dysphagia.</p> <p>Observations of resident #12 on February 14,</p>	F 221	<p>WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>Fair Oaks Health Systems to determine that resident #12, resident #20, and all residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Criteria 1: Resident #12 has been assessed for least restrictive fall risk interventions with review/revision of the care plan to include discontinuing of the side rails and reduce/eliminate restraint use to low bed with a concave mattress and landing strips on February 17,2011. (See attachment 1)</p> <p>Resident #20 has been assessed for least restrictive fall risk interventions with review/revision of the care plan to include discontinuing of the Velcro Belts while in wheelchair and in bed; reduce/eliminate restraint use to low bed with a concave mattress and landing strip; and reduce/eliminate the wheelchair cushion to SupportPro Anti Thrust Cushion per Occupational therapy on February 23, 2011. (See attachment 2)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 3/16/2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221 Continued From page 1
2011, at 2:45 p.m., 4:05 p.m., 5:35 p.m., and 7:30 p.m., revealed the resident to be in bed. Full side rails were observed to be padded and in the "up" position bilaterally which also restricted the resident's visual field. Resident #12 was turned and repositioned every two hours by staff, but was not observed to attempt to roll out of bed or attempt to place his/her limbs near the pads. Observations of resident #12 revealed the resident to be cognitively impaired and unable to communicate.

A review of the MDS assessment dated January 21, 2011, revealed resident #12 was severely cognitively impaired, rarely/never understood/understands, and was a totally dependent two-plus person physical assist with bed mobility/transfers. There was no assessment for the use of side rails for resident #12. A care plan was added to address the use of the full, padded side rails on February 15, 2011, during the survey process.

According to the resident's plan of care, the most recent falls sustained by the resident occurred on February 10, 2010 and February 12, 2010, when the resident rolled out of a low bed to a floor mat without injury.

A review of the "Siderail Assessment Screen" completed on January 21, 2011, revealed the resident was nonambulatory, had a history of falls, had demonstrated poor bed mobility, had difficulty with balance, was currently using the side rail for positioning/support, and was on medication requiring increased safety precautions. The side rail assessment screen also indicated a further evaluation was needed to determine the appropriateness of the side rails.

F 221 Continued from page 1

Criteria 2:
All residents currently utilizing side rails or belt type devices have the potential to be affected and have been assessed for least restrictive fall risk interventions and device use with review/revision of the side rail/device assessments and care plan to address the indicated interventions as completed by March 18, 2011.

Criteria 3:
Facility nursing staff have received inservice education to determine that facility residents will be assessed for fall management interventions and devices utilizing the least restrictive interventions that are determined to be the most appropriate and safest for the resident based on the fall investigation findings; the monitoring and release of the device; and the need to report observations indicating the need for device re-assessment; and to assess and attempt to eliminate/reduce restraints, as provided by Director of Nursing, ADON, Administrator, and Director of Clinical Services on March 17, 2011. (See attachment #14 - for facility nursing staff definition)

Facility MDS Coordinators have received inservice education to determine that facility residents will be assessed for fall management interventions and devices utilizing the least restrictive interventions that are determined to be the most appropriate and safest for the resident based on the fall investigation findings; the monitoring and release of the device; and the need to report observations indicating the need for device re-assessment; and to

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F 221	<p>Continued From page 2</p> <p>Staff comments included "continued to require padded side rails related to a history of rolling out of bed."</p> <p>A review of the "Physical Therapy Restraint Assessment" completed by the Physical Therapy Department on January 21, 2011, revealed the resident "continued to roll about in the bed and required side rails. No other restraint required at this time."</p> <p>A review of the "Physical Restraint Elimination Assessment" completed by the facility at quarterly intervals on August, 10, 2010, October 27, 2010, and January 21, 2011, for resident #12 revealed a number value was assigned to categories of functioning and the total score indicated whether the resident would be considered a poor, good, or priority candidate for restraint reduction or elimination based on the total numerical score. According to the elimination assessment, resident #12's ambulation was limited to "complete bedrest" - 3, weight bearing/transfers were marked "non-weight bearing" - 2, bed mobility - no value marked, sitting balance was marked "slides down" - 2, activities of daily living were marked "requires total assist of two" - 3, physical limitations marked with "history of falls" - 3, vision status - no value given, orientation was marked "disoriented in three spheres" - 3, comprehension - no value given, behavior/mood - no value given, activity participation was marked "participates with assistance - 1, and medication therapy was marked "not taking any chemical restraint - 0. According to the instructions, the values are to be totaled and depending on the total score the resident is rated as a "poor, good, or priority candidate" for restraint reduction/elimination. Resident #12 scored 17 on each of the quarterly</p>	F 221	<p>Continued from page 2</p> <p>assess and attempt to eliminate/reduce restraints, as provided by Director of Nursing, ADON, Administrator, and Director of Clinical Services on March 11 2011.</p> <p>CNA#1 and CNA#2 have received inservice education for fall management interventions and devices utilizing the least restrictive interventions that are determined to be the most appropriate and safest for the resident based on the fall investigation findings; the monitoring and release of the device; and the need to report observations indicating the need for device re-assessment; and to assess and attempt to eliminate/reduce restraints, as provided by Director of Nursing, ADON, Administrator, and Director of Clinical Services on March 17, 2011.</p> <p>Criteria 4: The Continuous Quality Improvement Indicator for the monitoring of the device/physical restraint use will be utilized monthly x 2 months and then quarterly thereafter under the supervision of the Director of Nursing. (See attachment 3)</p> <p>Criteria 5: March 18, 2011</p>	3/18/11
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F 221	<p>Continued From page 3</p> <p>assessments, which was an indication the resident was a "priority candidate" for restraint reduction or elimination; however, there was no evidence the facility had attempted to reduce or eliminate the restraint for resident #12.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on February 14, 2011, at 5:55 p.m., revealed the resident was totally dependent on staff for repositioning. CNA #2 stated the resident "depends on us to move (her/him) now and does not try to get out of bed anymore."</p> <p>An interview with the Minimum Data Set/Licensed Practical Nurse (MDS/LPN) conducted on February 15, 2011, at 2:10 p.m., revealed the facility utilized full, padded side rails for resident #12 because the resident rolled out of bed and placed her/his limbs between the rails. The MDS/LPN further stated, "They do restrain (her/him) I guess." A second interview with the MDS/LPN conducted on February 16, 2011, at 4:20 p.m., revealed the MDS/LPN had completed a "Pre-restraining Assessment" on August 10, 2010, and a "Physical Restraint Elimination Assessment" on August 10, 2010, October 27, 2010, and January 21, 2011. The MDS/LPN stated he/she was new to the MDS/LPN position in July 2010 and was unsure how to complete the assessment forms. The MDS/LPN did not know why the Pre-restraining Assessment and Physical Restraint Elimination Assessment were completed since he/she did not consider the padded side rails as a restraint. The MDS/LPN further stated he/she did not assess the side rails as a physical/visual restraint when completing the MDS assessment on January 21, 2011, and did not develop a care plan for their use for resident #12.</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>An interview with the Director of Nursing (DON) conducted on February 15, 2011, at 2:40 p.m., revealed the DON stated, "We didn't think of them as a restraint." A second interview with the DON was conducted on February 16, 2011, at 3:45 p.m. The DON stated the facility staff did complete a Physical Restraint Elimination Assessment quarterly. The DON further stated even though the Physical Restraint Elimination Assessment indicated the resident would be a priority candidate for restraint reduction, and the resident had no recent falls, the facility did not attempt to reduce/eliminate the restraint.</p> <p>2. Observations of resident #20 on February 16, 2011, at 9:50 a.m., revealed the resident to be asleep in a high-backed wheelchair with a pommel cushion and a Velcro belt in place. Observations on February 16, 2011, at 2:00 p.m. and 4:30 p.m., revealed resident #20 was in a low bed with a concave mattress, a fall mat at the bedside, and a Velcro belt across the resident's abdomen. The resident was observed to have his/her eyes closed. An interview with the Assistant Director of Nursing (ADON) on February 16, 2011, at 4:30 p.m., revealed the resident was able to remove the Velcro straps without problems; however, the ADON was unable to awaken the resident for a demonstration.</p> <p>A review of the medical record of resident #20 revealed the resident was admitted to the facility on November 1, 2007, with diagnoses of Alzheimer's Disease, Diabetes, Anxiety, and Congestive Heart Failure. A review of the resident's most recent comprehensive MDS (Minimum Data Set) assessment dated October</p>	F 221		

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F 221	<p>Continued From page 5</p> <p>19, 2010, revealed resident #12 was usually understood/understands others. According to the Care Area Assessment Summary (CAAS), dated October 19, 2010, resident #20 had impaired memory and severely impaired cognition with impaired decision-making ability.</p> <p>According to resident #20's care plan dated August 2, 2010, the resident utilized a Velcro strap (belt) in bed for the resident's safety to "decrease the likelihood of falls." The care plan stated the resident was able to release the straps at will with direction, however, was inconsistent with following directions to release the Velcro straps.</p> <p>Further review of the record revealed the facility had conducted "Physical Restraint Elimination Assessments" on August 2, 2010, October 19, 2010, and January 19, 2011. These assessments indicated the resident was a "good candidate" for restraint elimination or reduction. However, there was no evidence the facility attempted to reduce/eliminate the use of the Velcro belt for resident #20.</p> <p>An interview with the Minimum Data Set/Licensed Practical Nurse (MDS/LPN) conducted on February 16, 2011, at 4:20 p.m., revealed the MDS/LPN had not assessed the Velcro straps as a restraint since the resident was able to remove them. The LPN further stated even though the Velcro straps were not considered a restraint for resident #20, the LPN had completed the Physical Restraint Elimination Assessment on January 19, 2011, for resident #20. The MDS/LPN stated the resident was a priority candidate for reduction or elimination according to the Assessment, but the facility continued to use</p>	F 221			

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F 221	Continued From page 6 the Velcro straps related to the resident attempting to rise unassisted.	F 221			
F 242 SS=D	<p>An interview with the Director of Nursing (DON) conducted on February 16, 2011, at 3:45 p.m., revealed the facility did not attempt to reduce/eliminate restraints just because the numbers on the assessment indicated the resident would be a good candidate.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to accommodate the individual choices of one of twenty-three sampled residents (resident #10). Resident #10 was observed to be served food items for which the resident had indicated a dislike.</p> <p>The findings include:</p> <p>A review of the medical record for resident #10 revealed the resident was admitted to the facility on April 8, 2005, with diagnoses that included Diabetes, Senile Dementia, Cerebrovascular Accident, Hypertension, and Chronic Fatigue. A Nutrition Assessment completed by the facility on</p>	F 242	<p>SELF-DETERMINATION – RIGHT TO MAKE CHOICES</p> <p>Fair Oaks Health Systems to determine that Resident #10 and all residents have a right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Criteria1: Resident#10 was interviewed verifying resident's food likes and dislikes, with preferences documented on resident's meal card on February 17, 2011. Resident#10's Meal card was revised to determine that the resident is not served food which the resident had indicated as a dislike. (See attachment 4)</p> <p>Criteria 2: All residents were interviewed by Dietary Manager and responsible parties/families consulted for non-interviewable residents, to determine resident likes and dislikes and each resident's meal card was reviewed and revised to determine that all residents food dislikes were clearly legible and noted., completed by March 18, 2011.</p>		

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F 242	Continued From page 7 April 2, 2010, revealed the resident's physician had ordered a 2000-calorie low-fat diet and the resident had requested no cheese, broccoli, cabbage, or elbow macaroni. Observations of the evening meal for resident #10 on February 14, 2011, at 7:27 p.m. EST, revealed the resident's tray contained macaroni and cheese, broccoli, Salisbury steak, bread, fruit, Sugar Pops cereal, and beverages. A review of the resident's tray card listed foods the resident disliked as macaroni, cheese, and broccoli. An interview with resident #10 on February 14, 2011, at 7:30 p.m. EST, revealed the resident stated, "I never eat cheese, it makes me sick, and I don't like broccoli or macaroni." According to the resident, the staff was aware of food items the resident disliked but sent them anyway. An interview with the Registered Dietitian (RD) and Dietary Manager (DM) on February 14, 2011, at 7:35 p.m. EST, revealed there were three dietary staff members assigned to check trays for accuracy before the trays left the kitchen. According to the RD and DM, "they just missed it" (resident #10's food dislikes).	F 242	Continued from page 7 Criteria 3: Dietary Staff received inservice education by Registered Dietitian (RD) informing and addressing resident expressed likes and dislikes in order to honor these choices as provided by Dietary Services on March 8, 2011. Nursing Staff received inservice education by Registered Dietitian (RD) informing and addressing resident expressed like and dislikes in order to honor these choices as provided by Dietary Services on March 17, 2011. (See attachment #14 – for facility nursing staff definition) Criteria 4: The Continuous Quality Improvement Indicator for the monitoring of the residents trays ensuring the served food is what the resident has indicated as a like will be utilized weekly x 2 months and then monthly thereafter under the supervision of the Dietary Manager. (See attachment 5) Criteria 5: March 18, 2011	3/18/11	
F 258 SS=B	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide for the	F 258	MAINTENANCE OF COMFORTABLE SOUND LEVELS Fair Oaks Health Systems to determine that the maintenance of comfortable sound levels for resident #16 and all residents. Criteria 1: The ice machine located in the dining room has been relocated to another location outside the dining room on March 7, 2011.		

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F 258	<p>Continued From page 8</p> <p>maintenance of comfortable sound levels. A loud noise was identified coming from the ice dispenser in the main dining room of the facility during observations of meal service on February 14, 15, and 16, 2011.</p> <p>The findings include:</p> <p>An observation of the supper meal in the main dining room of the facility on February 14, 2011, at 5:50 p.m., revealed residents were in the dining room for the supper meal. The ice dispenser located in the main dining room was observed to be making a loud noise.</p> <p>A group interview conducted with 12 alert and oriented residents on February 15, 2011, at 3:00 p.m., revealed the noise from the ice dispenser in the main dining room was very loud. According to the group, it was hard to hear because of the loud noise from the ice dispenser.</p> <p>An interview conducted with resident #16 on February 16, 2011, at 10:20 a.m., revealed the resident felt it was too noisy in the dining room. The resident further stated, "You can't hear each other talk. The ice dispenser is too loud."</p> <p>An interview conducted with the facility's Administrator on February 16, 2011, at 9:45 a.m., revealed the Administrator was unaware of the ice dispenser being too loud and making it difficult for the residents to hear in the dining room.</p>	F 258	<p>Continued from page 8</p> <p>Criteria 2: The ice machine located in the dining room has been relocated to another location outside the dining room, so not to interfere with all residents dining experience on March 7, 2011.</p> <p>Criteria 3: Inservice training was conducted for all staff on the need to report equipment or circumstances which demonstrate a noisy environment in patient care areas, as provided by the Director of Nursing, ADON, and Director of Clinical services on 3/3/11.</p> <p>Inservice training was conducted on 3/10/11 for Maintenance staff on the need to report equipment or circumstances which demonstrate a noisy environment in patient care areas, as provided by the Administrator.</p> <p>Criteria 4: The Continous Quality Improvement Indicator for the monitoring of the facility noise levels will be utilized monthly x 2 months, and then every 6 months thereafter under the supervision of the Administrator. (See attachment 6)</p> <p>Criteria 5: March 10, 2011.</p>	3/10/11	
F 282 SS=G	<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</p>	F 282	<p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>Fair Oaks Health Systems to determine that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</p>		

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F 282	<p>Continued From page 9 care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that services were provided to one of twenty-three residents in accordance with the resident's plan of care. The facility failed to ensure the care plan intervention for one-to-one supervision to prevent falls was continuously implemented and staff was knowledgeable of the intervention. Resident #7 sustained a fall on January 9, 2011, at which time the facility initiated and care planned for staff to provide one-to-one supervision to prevent falls. The facility failed to provide one-to-one supervision after 1:00 p.m. on January 9, 2011. On January 13, 2011, the resident fell and sustained a hip fracture requiring surgical repair. Upon return, the facility maintained the intervention for one-to-one supervision, however, failed to ensure staff was implementing the care plan as written.</p> <p>The findings include:</p> <p>A review of the medical record for resident #7 revealed the resident was admitted to the facility on January 3, 2007, with diagnoses that included Alzheimer's Disease, Depression, Anxiety, Congestive Heart Failure, Parkinson's Disease, Gastroesophageal Reflux Disease, and Cerebrovascular Accident. A comprehensive Minimum Data Set (MDS) assessment dated December 17, 2010, revealed the facility assessed resident #7 as at risk for falls due to impaired balance during transitions, an unsteady gait, use of anti-anxiety agents, antidepressant</p>	F 282	<p>Continued from page 9</p> <p>written plan of care to Resident #7 and all other Residents.</p> <p>Criteria 1: Resident #7 has been assessed related to the fall risk with review/revision of the care plan to include interventions to prevent falls, and to determine that services provided Resident #7 are in accordance with Resident's #7 Plan of Care as completed by February 17, 2011. The one to one supervision for Resident #7 was discontinued and the interventions related to the fall risk on the revised care plan included: a) Therapy to evaluate and treat as ordered; b) bed in low position when abed with soft padded landing strips to bilateral sides of bed; c) Scheduled toileting program as ordered, i.e. assist to BSC/BR before and after meals, HS, & PRN as the resident will accept; d) Sensor pad alarm to bed and chair to alert staff of unassisted transfers; e) Assist with transfers, ambulation, & locomotion via w/c as needed; f) Provide environment conducive for sleep/rest: i.e., dim lights, decrease excessive background noise as possible, assess for pain and admin. PRN analgesics as ordered, provide for needs/ wants, provide assist with toileting as needed, and provide snacks as desired; g) Give medications as ordered and observe for adverse effects; h) Involve resident as resident will accept in activities that minimize risk for falls and provide diversion/distraction as possible; i) Attempt to determine reason for transfers without assist and provide for needs/wants promptly; and j) Encourage rest/relaxation as needed. (See attachment 7)</p>	

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F 282	<p>Continued From page 10</p> <p>agents, antipsychotic agents, diuretic medications, cognitive impairment, and a history of falls within the previous 180 days. A review of the comprehensive care plan revealed interventions including: provide assistance of one staff person for transfers and ambulation, keep the call light within reach, reinforce the need to call for assistance, provide a safe environment, and encourage the proper use of handrails and/or assistive devices.</p> <p>A review of the plan of care revealed resident #7 sustained a fall on January 9, 2011, and an intervention was added to "Apply one on one with resident" on January 9, 2011; however, review of the "Event Report Investigation" dated January 9, 2011, revealed the staff observed resident #7 one to one at the nurses' station from 11:30 a.m. until 1:00 p.m. on January 9, 2011. There was no evidence staff provided one-to-one supervision after 1:00 p.m. on January 9, 2011.</p> <p>An interview with the Licensed Practical Nurse/Minimum Data Set Coordinator (LPN/MDS) for D Wing was conducted on February 16, 2011, at 10:40 a.m. The LPN/MDS stated resident #7 walked with a walker and was very unsteady but the LPN/MDS felt the resident was safe to ambulate with the assistance of one staff member as care planned. The LPN/MDS stated he/she was responsible for updating the resident's care plan following falls and had added the intervention to "Apply one-on-one with the resident."</p> <p>An interview with the Director of Nursing (DON) conducted on February 16, 2011, at 10:45 a.m., revealed the IDT reviewed the Event Report Investigation after resident #7 fell on January 9, 2011. The DON stated the IDT was aware</p>	F 282	<p>Continued from page 10</p> <p>Criteria 2: All residents with falls in the last 90 days have the potential to be affected, and have been assessed related to the fall risk with review and revision of the care plan to address the indicated interventions, as completed by March 18, 2011</p> <p>Criteria 3: Facility Nursing staff have received inservice education provided by the Director of Nursing, ADON, Administrator, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan; the intervention of one to one supervision was reviewed and discussed to provide knowledge of appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event in accordance with the initial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 11, 2011. (See attachment #14 - for facility nursing staff definition)</p> <p>Facility MDS Coordinators have received inservice education provided by the Director of Nursing, ADON, Administrator, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan; the intervention of one to one supervision was reviewed and discussed to provide knowledge of appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event</p>		

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F 282	<p>Continued From page 11</p> <p>resident #7 was assisted to the nurses' station on January 9, 2011, and staff provided one-on-one supervision for one and one-half hours following the resident's fall. According to the DON, he/she did not realize the care plan required continuous supervision.</p> <p>A review of the "Event Report Investigation" dated January 13, 2011, revealed resident #7 sustained a fall at 3:30 a.m. in the resident's room. According to the investigation, at 3:15 a.m., resident #7 was sitting in the bedside chair and declined to go to bed; at 3:30 a.m., the resident was found on the floor, and staff assisted the resident back to bed and sat with the resident for one hour. According to the event report, the resident was transferred to the hospital due to being unable to bear weight. According to resident #7's care plan, the resident was diagnosed with a right hip fracture on January 14, 2011, and was transferred to the hospital for surgical repair of the hip. There was no evidence one-on-one supervision was being provided prior to the January 13, 2011 fall.</p> <p>A review of the plan of care for resident #7 following the resident's return from the hospital on January 19, 2011, revealed the resident continued to require one-to-one supervision and physical therapy for evaluation and treatment. In addition, the facility implemented a personal alarm for resident #7.</p> <p>Observations of resident #7 on February 17, 2011, at 2:53 p.m., revealed the resident was lying in a low bed with a fall mat to the right side of the bed and a personal alarm in use. Resident #7 was alert and responded to questions; however, content of the responses was not</p>	F 282	<p>Continued from page 11</p> <p>in accordance to the intitial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 11, 2011.</p> <p>CNA #2 has received inservice education provided by the Director of Nursing, ADON, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan; the intervention of one to one supervision was reviewed and discussed to provide knowledge of appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event in accordance to the intitial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 17, 2011</p> <p>Criteria 4: The Continous Quality Improvement Indicator for monitoring of fall prevention interventions in accordance with the care plan will be utilized monthly x 2 months and then quarterly thereafter under the supervision of the Director of Nursing. (See attachment 8)</p> <p>Criteria 5: March 18, 2011</p>	3/18/11	

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F 282	Continued From page 12 always appropriate. Continued observations throughout the day at 4:08 p.m., 5:45 p.m., and 7:15 p.m., revealed a personal alarm was in use for resident #7; however, there were no observations of continuous one-to-one supervision being provided by facility staff. An interview with Certified Nursing Assistant (CNA) #2 conducted on February 17, 2011, at 11:50 a.m., revealed resident #7 attempted to ambulate and transfer often without staff assistance prior to the falls. CNA #2 also stated the resident was not as unsteady then. CNA #2 further stated the staff was to provide assistance with transfers and ambulation; however, CNA #2 was unaware one-to-one supervision was required for resident #7.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide necessary care and services for one of twenty-three sampled residents (resident #7) to maintain the highest practicable physical well being. The facility failed to ensure the resident's call light was accessible to resident #7. The findings include:	F 309	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Fair Oaks Health Systems to determine that for Resident #7 and all residents will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Criteria 1: Resident #7 has been assessed on February 17, 2011 related to call light use with review/revision of the care plan to include interventions of exchanging call light to large pad call light to enable easier access to call system and to determine that services provided Resident #7 are in accordance with Resident's #7 comprehensive assessment and plan of care. (See attachment 9)	

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F 309	<p>Continued From page 13</p> <p>1. Observations of resident #7 on February 15, 2011, from 2:10 p.m. until 3:15 p.m., revealed the resident was sitting in a wheelchair in the resident's room. The resident's call light was observed to be on the resident's bed behind the resident's chair. Staff was observed entering and exiting the resident's room three times to assist the resident's roommate, however, did not observe resident #7's call light was not accessible for the resident's use.</p> <p>A review of the medical record for resident #7 revealed the resident was admitted to the facility on January 3, 2007, with diagnoses that included Alzheimer's Disease, Depression, Anxiety, Cerebrovascular Accident, Parkinson's Disease, and Congestive Heart Failure. The most recent Minimum Data Set (MDS) assessment completed on December 14, 2010, revealed the resident was moderately impaired with daily decision-making, was easily understood, and usually understood others. The plan of care indicated staff was responsible for keeping the call light within reach when in the room at all times.</p> <p>An observation and interview with Certified Nursing Assistant (CNA) #2 at 3:05 p.m. on February 15, 2011, revealed the resident's call light was not accessible. The CNA stated he/she had not noticed the resident's call light was out of reach. CNA #2 stated it should be within reach at all times; however, CNA #2 did not place the call light within reach of the resident.</p> <p>An observation and interview with the Director of Nursing (DON) on February 15, 2011, at 3:20 p.m., in resident #7's room revealed the resident's call light was placed on the resident's bed out of</p>	F 309	<p>Continued from page 13</p> <p>Criteria 2: All residents with falls in the last 90 days have the potential to be affected, and have been assessed related to call light use with review/revision of the care plan to address the indicated interventions, as completed by March 18, 2011.</p> <p>Criteria 3: Facility Nursing staff have received inservice education as provided by the Director of Nursing, ADON, and Director of Clinical services to determine that the resident's call lights are accessible and within reach of the resident as provided on March 17, 2011 (See attachment #14 – for facility nursing staff definition)</p> <p>Facility non-nursing staff have received inservice education as provided by the Director of Nursing, ADON, and Director of Clinical services to determine that the resident's call lights are accessible and within reach of the resident as provided on March 3, 2011.</p> <p>CNA#2 has received inservice education as provided by the Director of Nursing, ADON, and Director of Clinical services to determine that the resident's call lights are accessible and within reach of the resident as provided on March 17, 2011</p> <p>Criteria 4: The Continous Quality Improvement indicator for the monitoring of call light accessibility will be utilized monthly x 2 months and then quarterly thereafter under the supervision of the Director of Nursing. (See attachment 10)</p>	

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F 309

Continued From page 14
sight and reach of the resident. The DON stated the housekeeping staff assisted with transporting residents back from the dining room and should have made sure the resident's call light was accessible. According to the DON, all staff was to ensure residents have access to a call light. The DON repositioned the resident's wheelchair and call light to ensure the resident could use the call light to summon staff if needed.

F 309

Continued from page 14

Criteria 5: March 18, 2011

3/18/11

F 323
SS=G

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide a safe environment and adequate supervision to prevent accidents for one of twenty-three sampled residents. The facility failed to follow the "Accident Prevention Policy." The facility assessed and identified resident #7 was at risk for falls. On January 9, 2011, resident #7 sustained a fall. While the facility developed an intervention for one-to-one supervision to prevent further falls, the facility failed to implement the intervention. This failure resulted in resident #7 falling on January 13, 2011, sustaining a hip fracture which required surgical repair. Additionally, while the facility maintained one-to-one supervision as an intervention for

F 323

FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Fair Oaks Health Systems will determine that Resident #7 and all other residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Criteria 1:
Resident #7 has been assessed on February 17, 2011 related to fall risk with review/revision of the care plan to include interventions to ensure a safe environment and adequate supervision to prevent accidents; and to determine that services provided Resident#7 in accordance with Resident's#7 Plan of Care. The one to one supervision for Resident #7 was discontinued and the interventions related to the fall risk on the revised care plan included: a) Therapy to evaluate and treat as ordered; b) bed in low position when abed with soft padded landing strips to bilateral sides of bed; c) Scheduled toileting program as ordered, i.e. assist to BSC/BR before and after meals, HS, & PRN as the resident will accept; d) Sensor pad alarm to bed and chair to alert staff of unassisted transfers; e) Assist with transfers,

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F 323	<p>Continued From page 15</p> <p>resident #7 upon return to the facility, the facility failed to ensure staff was knowledgeable of the intervention and that it was implemented.</p> <p>The findings include:</p> <p>A review of the facility's "Accident Prevention Policy", no date given, revealed the staff's actions following a fall should include: 1. Ascertaining if there were injuries, provide treatment as necessary, 2. Determining what may have caused/contributed to the fall, 3. Addressing the factors for the fall, and 4. Revising the resident's plan of care and/or facility practices as needed to reduce the likelihood of another fall. Further review of the "Policy on Post Falls/Accidents," no date given, revealed the Interdisciplinary Team (IDT) was to investigate Post Falls/Accidents. The IDT was to: 1. Review falls for contributing factors, 2. Evaluate and analyze hazards and risks of falls/accidents., 3. Implement interventions to reduce hazards and risks for falls/accidents, 6. Assess for appropriate assistive devices/alarms to prevent falls/accidents, and 7. Modify interventions as necessary. There was no evidence the facility followed their policies to address resident #7's falls.</p> <p>A review of the medical record for resident #7 revealed the resident was admitted to the facility on January 3, 2007, with diagnoses that included Alzheimer's disease, Depression, Anxiety, Congestive Heart Failure, Parkinson's Disease, Gastroesophageal Reflux Disease, and Cerebrovascular Accident. A comprehensive Minimum Data Set (MDS) assessment dated December 17, 2010, revealed the facility assessed resident #7 as at risk for falls due to impaired balance during transitions, an unsteady</p>	F 323	<p>Continued from page 15</p> <p>ambulation, & locomotion via w/c as needed; f) Provide environment conducive for sleep/rest: i.e., dim lights, decrease excessive background noise as possible, assess for pain and admin. PRN analgesics as ordered, provide for needs/ wants, provide assist with toileting as needed, and provide snacks as desired; g) Give medications as ordered and observe for adverse effects; h) Involve resident as resident will accept in activities that minimize risk for falls and provide diversion/distraction as possible; i) Attempt to determine reason for transfers without assist and provide for needs/wants promptly; and j) Encourage rest/relaxation as needed. (See attachment 7)</p> <p>Criteria 2: All residents with falls in the last 90 days have the potential to be affected, and have been assessed related to fall risk with review and revision of the care plan to address the indicated interventions as completed by March 18, 2011.</p> <p>Criteria 3: Facility Nursing Staff have received inservice education as provided by DON, ADON, Administrator, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan to provide a safe environment and adequate supervision to prevent accidents; review/discussion of facility's "Accident Prevention Policy" and "Post Fall/Accident Policy"; the intervention of one to one supervision was reviewed and discussed to determine knowledge of</p>		

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F 323	<p>Continued From page 16</p> <p>gait, use of anti-anxiety agents, antidepressant agents, antipsychotic agents, diuretic medications, cognitive impairment, and a history of falls within the previous 180 days.</p> <p>A review of the comprehensive care plan initiated on January 16, 2007, revealed the facility identified resident #7 was at risk for falls and developed interventions including: provide assistance of one staff person for transfers and ambulation, keep the call light within reach, reinforce the need to call for assistance, provide a safe environment, and encourage the proper use of handrails and/or assistive devices.</p> <p>A review of the Event Report Investigation, dated January 9, 2011, revealed the resident was found on the floor in the resident's room. According to the investigation, the facility assessed resident #7, noted initially no discolored areas, and the resident denied pain/discomfort. Possible causative factors were listed as "started to set in bedside chair and misjudged the distance, missing the front of the chair." Other causes/contributors were listed as "Unsteady gait, non-compliance with assisted transfers, does not recognize physical limitations and thinks he/she can still be independent." While the "Event Report Investigation" revealed staff observed resident #7 one-to-one at the nurses' station from 11:30 a.m. until 1:00 p.m. on January 9, 2011, record review of the falls risk care plan, updated on January 9, 2011, after resident #7 sustained the fall, revealed an intervention was added of, "Apply one on one with resident." There was no documented evidence staff provided one-to-one supervision after 1 p.m. on January 9, 2011.</p> <p>An interview conducted on February 16, 2011, at</p>	F 323	<p>Continued from page 16</p> <p>appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event in accordance with the initial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 17, 2011 (See attachment #14 – for facility nursing staff definition)</p> <p>Facility PTA , Facility MDS Coordinators, and Interdisciplinary Team have received inservice education as provided by DON, ADON, Administrator, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan to provide a safe environment and adequate supervision to prevent accidents; review/discussion of facility's "Accident Prevention Policy" and "Post Fall/Accident Policy"; the intervention of one to one supervision was reviewed and discussed to determine knowledge of appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event in accordance with the initial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 14, 2011.</p> <p>CNA #1 & CNA#2 have received inservice education as provided by DON, ADON, and Director of Clinical Services on the provision of fall prevention interventions in accordance with each resident's care plan to provide a safe environment and adequate supervision to prevent accidents;</p>	

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F 323	<p>Continued From page 17</p> <p>11:50 a.m., with Certified Nursing Assistant (CNA) #2, the CNA providing care for resident #7, revealed the CNA was unaware resident #7 required one-on-one supervision.</p> <p>An interview with the Licensed Practical Nurse/Minimum Data Set Coordinator (LPN/MDS) for D Wing was conducted on February 16, 2011, at 10:40 a.m. The LPN/MDS stated resident #7 walked with a walker and was very unsteady but the LPN/MDS felt the resident was safe to ambulate with the assistance of one staff member as care planned. The LPN/MDS stated he/she was responsible to update the resident's care plan following the falls and had added the intervention to "Apply one-on-one with the resident." The LPN/MDS further stated he/she did not set a timeframe regarding the intervention; however, the one-to-one was continued for one and one-half hours following the fall on January 9, 2011.</p> <p>An interview with the Director of Nursing (DON) conducted on February 16, 2011, at 10:45 a.m., revealed the Interdisciplinary Team (IDT) consisting of department heads and administration met weekly to discuss care issues/concerns including falls that occurred the previous week. According to the DON, documentation, including nurse's notes, care plans, and Event Report Investigations, was to be reviewed during these meetings. According to the DON, the IDT would have met on Monday, January 10, 2011, following the first fall sustained by resident #7 on January 9, 2011. The DON stated the IDT reviewed the Event Report Investigation after resident #7 fell on January 9, 2011. The DON stated the IDT was aware resident #7 was assisted to the nurses' station on</p>	F 323	<p>Continued from page 17</p> <p>review/discussion of facility's "Accident Prevention Policy" and "Post Fall/Accident Policy"; the intervention of one to one supervision was reviewed and discussed to determine knowledge of appropriate usage; inservice education upon immediate interventions that can be implemented at the time of an event in accordance with the initial investigation findings; each intervention was reviewed and discussed to determine the care plan as written was continuously implemented and staff was knowledgeable of the interventions as provided on March 17, 2011</p> <p>Criteria 4: Members of the QA committee using the CQI indicator for the monitoring of fall prevention interventions in accordance with the care plan will be utilized monthly x 2 months and then quarterly thereafter under the supervision of the DON. (See attachment 8)</p> <p>Criteria 5: March 18, 2011</p>	3/18/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2011
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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629
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F 323	<p>Continued From page 18</p> <p>January 9, 2011, and staff provided one-on-one supervision for one and one-half hours following the resident's fall. According to the DON, the IDT did not realize the care plan required continuous supervision; however, there was no documented evidence that the IDT met and discussed the resident's January 9, 2011 fall. Furthermore, interview on February 16, 2011, at 3:00 p.m., with the Physical Therapist Aide (PTA), who is a part of the IDT, revealed that she was unaware of the fall occurring on January 9, 2011.</p> <p>A review of an Event Report Investigation, dated January 13, 2011, revealed the resident was found on the floor near the entrance of the resident's room with the walker in front of the resident at 3:30 a.m. Possible causative factors for the fall were listed as dementia and progressing Alzheimer's and noncompliance with assistance for transfers. The recommended intervention was "Staff to sit one-on-one with the resident till ready to go to bed when he/she declines to go to bed at the routine bedtime. Provide calming." According to the care plan updated on January 13, 2011, staff was to "Apply 1:1 staffing with resident, assist back to bed to rest."</p> <p>A review of the nurse's notes, dated January 14, 2011, at 5:00 p.m., revealed resident #7 complained of pain and the nurse observed the resident's right leg was not extending normally. The facility notified the physician and transferred resident #7 to the Emergency Room for an evaluation. The resident was found to have sustained a fractured right hip which required surgical repair.</p> <p>An interview with the Director of Nursing (DON)</p>	F 323		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2011
NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629	
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F 323	<p>Continued From page 19</p> <p>conducted on February 16, 2011, at 10:45 a.m., revealed the IDT should have met again on Monday, January 17, 2011, following the second fall sustained by the resident on January 13, 2011, and reviewed the resident's fall. However, there was no documented evidence the facility updated the resident's care plan with other interventions to prevent falls or reviewed, and there was no documented evidence that the facility's IDT met regarding resident #7's January 13, 2011 fall. Additionally, further interview with the PTA revealed the staff was to notify PT of any falls sustained by residents to ensure an evaluation was completed by the Physical Therapy Department; however, the PTA stated she did not receive any notification of either of resident #7's falls and therefore no assessment was completed by the Physical Therapy Department.</p> <p>Record review revealed resident #7 returned to the facility on January 19, 2011. A review of the plan of care for resident #7 following the resident's return from the hospital revealed the resident continued to require one-to-one supervision and physical therapy for evaluation and treatment. In addition, the facility implemented a personal alarm for resident #7.</p> <p>Observations of resident #7 on February 16, 2011, at 2:53 p.m., revealed the resident was in a low bed with a fall mat to the right side of the bed and a personal alarm in use. Continued observations throughout the day at 4:08 p.m., 5:45 p.m., and 7:15 p.m., revealed a personal alarm was in use for resident #7. There were no observations of one-to-one supervision provided for resident #7 by facility staff.</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>An interview conducted with Certified Nursing Assistant (CNA) #2 on February 16, 2011, at 11:50 a.m., revealed resident #7 was often noncompliant. CNA #2 stated the resident would get up without staff assistance frequently but at that time, before the fracture occurred, the resident was not as unsteady as he/she has been since returning from the hospital and was unaware the resident required one-to-one supervision after both falls and at present time. CNA #2 further stated the resident had not utilized a personal alarm until after he/she returned from the hospital.</p> <p>While the facility's event investigation detailed that the interventions prior to the fall were effective, the investigation did not identify that staff had not been providing the care planned intervention of one-to-one supervision. Furthermore, interview with the LPN/MDS also revealed he/she was responsible to ensure that documentation related to the fall was in the nurse's notes; however, she did not complete the required documentation.</p> <p>An interview with the facility Administrator on February 16, 2011, at 3:15 p.m., revealed the facility did not follow their Accident Prevention Policy.</p>	F 323		
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p>	F 364	<p>NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Fair Oaks Health Systems to determine that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p>	

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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629		
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F 364	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide food that was at the proper temperature. Observation of the evening meal on February 14, 2011, revealed buttermilk and a health shake were served at a temperature above the recommended point of service temperature.</p> <p>The findings include:</p> <p>Observation on February 14, 2011, of the evening meal on the C Wing, revealed the meal cart was delivered to the wing at 6:00 p.m. The last tray to be delivered from the cart was delivered at 6:35 p.m. The surveyor requested a test tray. The temperature of the buttermilk on the test tray read 69.3 degrees Fahrenheit. The temperature of the health shake was 64.2 degrees Fahrenheit. The temperatures were verified with the facility's Registered Dietitian (RD) and another surveyor who was present.</p> <p>A review of the facility's policy, dated May 2010, revealed cold food would be served at a temperature of 41 to 45 degrees Fahrenheit.</p> <p>An interview with the RD on February 16, 2011, at 8:45 a.m., revealed the point-of-service temperature for milk was to be 41 to 45 degrees Fahrenheit. The RD was unaware of the length of time the trays were on the unit prior to being delivered to the residents.</p> <p>An interview was conducted with the Certified Nursing Assistant (CNA) who was assigned to the C Wing of the facility on February 15, 2011, at 2:55 p.m. The CNA stated the trays on the C</p>	F 364	<p>Continued from page 21</p> <p>Criteria 1: Fair Oaks Health Systems on March 18, 2011 has added the Ready-Chill system from Aladdin to determine that the shake supplements, buttermilk, and other dairy based liquids are served at a recommended point of service temperature. (See attachment 11)</p> <p>Criteria 2: All residents with shake supplements, buttermilk, and other dairy based liquids are served using the Ready-Chill bases to determine they are served at a recommended point of service temperature.</p> <p>Criteria 3: Facility Nursing and Dietary staff have received inservice education on the need to serve shake supplements, buttermilk, and other dairy based liquids refrigerated to maintain proper temperature and timeframes required for the trays to be delivered to the residents as provided by the Registered Dietician on March 17, 2011.</p> <p>Criteria 4: The Continuous Quality Improvement indicator for the monitoring of food/Liquid temperatures will be utilized weekly x 2 months and then monthly under the supervision of the Dietary Manager. (See attachment 5b).</p> <p>Criteria 5: March 18, 2011</p>	3/18/11	

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F 364	Continued From page 22 Wing usually took until 6:30 p.m. every evening to be served to residents. The CNA was unaware of any timeframe required for the trays to be delivered to the residents. The CNA further revealed he/she was unaware of the length of time allowed to deliver a tray to a resident before the tray should be replaced.	F 364			
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Four resident rooms were observed to have scarrred walls and one resident room was observed to have a hole in the wall. The findings include: Environmental observation conducted on February 15, 2011, at 2:00 p.m., revealed resident rooms 7, 34, 36, and 45 were observed to have scarring to the paint and drywall. In addition, a hole was observed in resident room 36 behind the doorknob. An interview conducted with the facility Maintenance Director on February 16, 2011, at 2:30 p.m., revealed the Maintenance Director made daily rounds to identify items in need of	F 465	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON Fair Oaks Health Systems to determine that a safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. Criteria 1: Fair Oaks Health Systems repaired the drywall and repainted the resident rooms 7, 34, 36, and 45 on March 11, 2011. Fair Oaks Health Systems repaired and repainted the hole observed in resident room 36 behind the doorknob on March 11, 2011. Criteria 2: An inspection was conducted by facility Administrative staff and Director of Maintenance on March 11, 2011 of all resident rooms and common areas to identify necessary repairs and painting. All areas have been prioritized and scheduled for completion. Criteria 3: Maintenance staff have received inservice education on the need to routinely inspect resident rooms and common areas to identify and address all necessary repairs or painting as provided by Administrator and Director of Clinical Services on March 11, 2011.		

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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629		
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F 465	Continued From page 23 repair and that maintenance forms were at the nurses' stations to be utilized by staff to indicate items in need of repair. Further interview revealed the Maintenance Director was not aware of the scarred walls, and the hole in the wall had been repaired but the door had reopened the hole, and no report had been received to indicate the hole had been reopened.	F 465	Continued from page 23 Criteria 4: The Continuous Quality Improvement indicator for the monitoring of the facility general environment will be utilized monthly x 2 months and then every quarter thereafter under the supervision of the Administrator.(See attachment 6b) Criteria 5: March 18, 2011	3/18/11	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the clinical record for one of twenty-three sampled residents was accurately documented. Resident #8 had a physician's order dated January 15, 2009, to discontinue consultations with the resident's allergy physician. However, the physician's order to consult the allergy physician continued to be included on the resident's current physician's orders dated February 1, 2011.	F 514	RECORDS-COMplete/ ACCURATE/ACCESSIBLE Fair Oaks Health Systems to determine that clinical records on Resident #8 and all Residents in accordance with accepted professional standards and practices that are complete accurately documented; readily accessible and systemically organized. Fair Oaks Health Systems' clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes. Criteria 1: The order to clarify the allergy specialist consult has been obtained and a new allergy physician has been scheduled for resident #8 on March 16, 2011.(See attachment 12) Criteria 2: All residents charts have been audited to ensure all consults ordered the past 90 days have been implemented as indicated by March 11, 2011.		

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F 514	<p>Continued From page 24</p> <p>The findings include:</p> <p>A review of the medical record for resident #8 revealed the resident had been admitted to the facility on February 8, 2008, with diagnoses to include Senile Dementia, Dry Eye Syndrome, Allergic Rhinitis, Dizziness, and Giddiness. A review of the most current Minimum Data Set (MDS) for resident #8 dated January 3, 2011, revealed the resident had been coded to have Allergic Rhinitis. A review of the current physician's orders for resident #8 dated February 1, 2011, revealed the resident had an order to follow up in six months with the resident's allergy physician. The medical record further revealed a physician's order dated January 15, 2009, to discontinue the physician's orders to consult with the resident's allergy physician. However, the order to discontinue the consultation with the allergy physician of resident #8 had not been carried over to the current physician's orders. The last documentation provided by the facility for when the allergy physician had seen resident #8 was on July 15, 2008.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) for the facility on February 16, 2011, at 1:50 p.m., revealed the Medical Records Department reviewed all routine orders for accuracy, and the ADON was unaware of how the physician's order for resident #8 regarding the discontinuation of the allergy consultations had been missed.</p> <p>An interview conducted on February 16, 2011, at 1:35 p.m., with the Medical Records employee responsible for reviewing the medical record for resident #8 for accuracy, revealed the physician's order to discontinue the consultations for the</p>	F 514	<p>Continued from page 24</p> <p>Criteria 3: Licensed Nursing Staff and medical records staff have received inservice education on the need to accurately document the clinical record, verify telephone orders with monthly recap orders each month, and to obtain clarifications as indicated, as provided by the DON, ADON, Administrator, and Director of Clinical Services on March 11, 2011.</p> <p>Criteria 4: The Continuous Quality Improvement Indicator for the Monitoring of accuracy of Physician orders will be utilized on charts per monthly x 2 months and then quarterly thereafter under the supervision of the Director of Nursing. (See attachment 13)</p> <p>Criteria 5: March 18, 2011.</p>	3/18/11	

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F 514	Continued From page 25 allergy physician for resident #8 should not have been on the routine physician's orders. The employee further revealed he/she was unaware how the order had been missed. The employee further stated he/she was the only employee reviewing the medical records for accuracy. When asked for the facility's policy on reviewing medical records, the facility provided a job description for Medical Records. A review of the facility job description for Medical Records revealed the person in Medical Records is responsible and accountable for all aspects of the resident's medical record. Further review of the job description revealed the Medical Records employee is responsible for audits of all active medical record files.	F 514			

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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629		
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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on February 15, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
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.