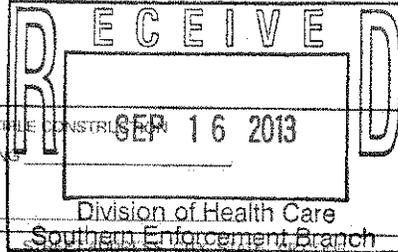


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  08/15/2013
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NAME OF PROVIDER OR SUPPLIER  WILLIAMSON ARH	260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 08/13-15/13. Deficient practice was identified at "D" level.	F 000		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one often sampled residents (Resident #9) maintained acceptable parameters of nutritional status. On 07/30/13, the facility's Dietitian made a recommendation for the amount of Resident #9's enteral feedings to be increased. However, a review of documentation on 08/15/13 revealed the facility had failed to address and/or notify the resident's physician of the recommendation, a timeframe of sixteen days.  The findings include:  An interview with the Director of Nursing (DON) on 08/15/13 revealed the facility did not have a	F 325	F325: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. On 8/15/2013 during State survey it was noted that a dietary recommendation had not been followed up on for resident #9. The form of communication of dietary recommendations was found to be ineffective. Previously the dietary recommendations had been placed in the RN box for review. It was found this was an ineffective practice. The practice was changed on 8/16/2013 with the implementation of a dietary recommendation book utilized to prevent loss of loose paper work. A in-service was provided on 8/16/2013 to staff to inform them in the change in practice (see attachment #1). The dietary recommendation book will be kept in the nurses station and reviewed at the beginning of 7a-7p shift by the RN/LPN's on duty. The sheet will be signed off by the staff member addressing the recommendation with the physician and monitored by the dietician for effectiveness of process 2. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken. All resident have the potential to be affected of the practice identified on 8/15/2013 during the survey because all residents have the potential to have dietary recommendations. An in-service of the staff was provided on a new process of utilization of dietary recommendation book on 8/16/2013. (see attachment #1). The book will be kept in the	9/5/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sarah K. Wasserman RN, BSN, DON, NHA</i> <i>Sarah D Wasserman RN, BSN, DON, NHA</i>	TITLE DON / Administrator	(X6) DATE 9/4/2013
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 325	<p>Continued From page 1</p> <p>written policy that specifically addressed dietary recommendations. According to the DON, it was facility practice for the Dietitian to place recommendations in a box at the nurses' station and the nurses would address the recommendations with the physician.</p> <p>Medical record review revealed Resident #9 had physician's orders for all fluids and nutrition to be administered through the resident's gastrostomy tube and for the resident to receive nothing by mouth. Continued review revealed physician's orders for Resident #9 to receive 250 milliliters of gastrostomy tube feedings three times a day. Additional record review revealed the resident's weight was 102.1 pounds on 07/29/13 and the Dietitian documented in the dietary notes the resident's weight was below the desired body weight range for the resident. At that time, the Dietitian documented a recommendation in the dietary notes for the resident's enteral feeding amount to be increased from 250 milliliters three times per day to 250 milliliters four times per day.</p> <p>Observation of Resident #9 conducted on 08/15/13 at 9:30 AM revealed the resident was receiving a gastrostomy tube feeding with the use of a tube feeding pump set to deliver feedings at 250 milliliters per hour three times daily. Facility staff weighed the resident during the observation and the resident weighed 104.4 pounds. According to documentation in the medical record, Resident #9's cognition was severely impaired and an interview was not attempted.</p> <p>An interview conducted with RN #1 on 08/15/13 at 11:20 AM, revealed she had seen the Dietitian's recommendation for the increase in Resident #9's tube feeding after the Dietitian had</p>	F 325	<p>cont. F 325</p> <p>nurses' station and utilized to help prevent loss of loose paper work with daily checks performed by the RN/LPN's to check for new or additional dietary recommendations to be reviewed with the appropriate physicians. The book will be monitored at least weekly by the dietitian and the DON in the absence of the dietitian. A PI monitor will be placed to monitor the effectiveness of the change in process (see attachment #2).</p> <p>3. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur. In-service of the staff concerning the process of utilization of dietary recommendation book was performed on 8/16/2013 (see attachment #1). The book will be kept in the nurses' station and utilized to help prevent loss of loose paper work with daily checks performed by the RN/LPN's to check for new or additional dietary recommendations to be reviewed with the appropriate physicians. The book will be monitored at least weekly by the dietitian and the DON in the absence of the dietitian. A PI monitor will be placed to monitor the effectiveness of the change in process (see attachment #2).</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Minimum of weekly PI check will be performed by the dietitian or the DON in the absence of the dietitian, to ensure the utilization of the dietary recommendation book (see attachment #2).</p>		

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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	
F 325	Continued From page 2 placed the recommendation in a box at the nurses' station but was not aware why the recommendation had not been addressed by the physician or why she had not notified the resident's physician of the recommendation.  An interview conducted with the Facility Dietitian on 08/15/13 at 11:30 AM revealed dietary recommendations are placed in a box at the nurses' station and the nurses are responsible to notify the physician of the recommendations. According to the Dietitian, she would not have known the recommendation was not addressed unless the resident had a weight loss that would have prompted her to review the resident's tube feeding orders. According to the Dietitian, the facility did not have a system to follow up to ensure dietary recommendations were addressed.  An interview conducted with the Director of Nursing (DON) on 08/15/13 at 2:45 PM, revealed it was Nursing's responsibility to address the dietary recommendations after they were placed in the box in the nursing unit and the facility did not check to ensure that Nursing followed up on the recommendation until the Dietitian completed the next review of the resident.	F 325			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by:	F 332	F 332 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. During the state survey on 8/15/2013 during medication pass it was found that G tube medications were not being administered as by new guidelines with the indication for administration of each G tube medications to be administered separately followed by a flush between each medication. This resulted in a medication error rate of greater than 5%. An in-service was provided to RN/LPN staff who have	9/5/2013	

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F 332	<p>Continued From page 3</p> <p>Based on observation, interview, and a review of facility policy, the facility failed to ensure the medication error rate was less than five percent. An observation of facility staff administering medications to residents on 08/14/13 revealed facility staff failed to administer each medication separately and flush the tubing between each medication for one of ten sampled residents (Resident #5) and two unsampled residents (Residents A and B) in accordance with standards of practice identified in Survey and Certification Letter 13-02 NH and "A.S.P.E.N enteral nutrition practice recommendations." As a result of the failure, the facility's medication error rate was eleven percent.</p> <p>The findings include:</p> <p>A review of the facility policy for medication administration dated February 2013 revealed the policy did not include procedures for the administration of medications through a gastrostomy tube. A review of standards of practice recommendations, "A.S.P.E.N. enteral nutrition practice recommendations, <a href="http://www.guidelines.gov/content.aspx?id=14718-03/15/10">http://www.guidelines.gov/content.aspx?id=14718-03/15/10</a>" revealed each medication should be administered separately and the tubing flushed between each medication.</p> <p>Observation of medication administration conducted for Resident A on 08/14/13 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #1 placed one tablet of Hydrochlorothiazide (HCTZ) 12.5 milligrams (mg), two tablets of Furofief 0.1 mg, and one tablet of Metoprolol 12.5 mg in a pill crusher, crushed the pills, and dissolved the pills in water. LPN #1 was observed to draw the dissolved medications into a syringe and inject</p>	F 332	<p>cont F332</p> <p>the potential to pass medications on 8/16/2013 (see attachment #3). The in-service provided them with process and copy of new medication administration policy to be implemented (see attachment #4). The new process includes for continued check of placement prior to administration of medications and continued flush of 30 ml flush prior to administration of medications with each medication given separately with a flush of 5 - 10 ml flush between each and then a flush of 30 ml upon completion of medication administration (see policy attachment #4).</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: All residents with G tubes have the potential to be impacted by this practice. Staff were in serviced concerning the new policy and procedure changes on 8/15/2012 (see attachment #3 and #4) concerning the changes in administration of medications via G tube. The new policy and process of medication administration includes for continued check of placement of tube prior to administration of medications and continued flush of 30 ml prior to administration of medications with each medication given separately with a flush of 5 - 10 ml between each medication and 30 ml flush upon completion of medication administration (see policy attachment #4).</p> <p>3. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur: Staff were in serviced concerning the new policy and procedure changes on 8/15/2012 (see attachment #3 and #4) concerning the changes in administration of medications via G tube. The new policy and process of medication administration includes for continued</p>	

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F 332	<p>Continued From page 4.</p> <p>the medications into the resident's gastrostomy tube. LPN #1 was observed to flush the gastrostomy tube prior to administering the medications and after administering the medications with 30 milliliters of water by injecting the water into the gastrostomy tube with a syringe.</p> <p>Observation of medication administration conducted for Resident B on 08/14/13 at 10:00 AM revealed LPN #1 crushed and dissolved the following medications in the same cup: Loratadine 10 mg, Sertraline 100 mg, Dilantin 150 mg, Docusate liquid 10 milliliters, Potassium Chloride 40 milliequivalents, and Valium 5 mg. LPN #1 was observed to inject Resident B's gastrostomy tube with 30 milliliters of water and then proceed to draw the dissolved medication into the syringe and inject the medications into the resident's gastrostomy tube. After LPN #1 finished injecting the medication into the resident's gastrostomy tube, she flushed the gastrostomy tube with 30 milliliters of water.</p> <p>Medication administration observation for Resident #5 conducted by LPN #2 on 08/14/13 at 10:20 AM revealed the LPN crushed and dissolved Phenobarbital 60 mg, Dilantin 200 mg, Coreg 12.5 mg, Lasix 40 mg, Plavix 75 mg, and Potassium Chloride 40 milliequivalents into the same cup with water. LPN #2 was observed to inject 30 milliliters of water into Resident #5's gastrostomy tube, drew the medication into a syringe, and injected the medications into the resident's gastrostomy tube. After injecting the medications LPN #2 again injected Resident #5's gastrostomy tube with 30 milliliters of water.</p> <p>Interview with LPN #1 on 08/14/13 at 11:15 AM</p>	F 332	<p>cont F332</p> <p>check of placement of tube prior to administration of medications and continued flush of 30 ml prior to administration of medications with each medication given separately with a flush of 5 - 10 ml between each and 30 ml flush upon completion of medication administration (see policy attachment #4). A PI monitor of a minimum of weekly random medication pass checks will be performed by the DON and/or MDS coordinator in her absence (see attachment #5) to ensure the implementation of the process of administration of each medication separately as per in-service and policy change (see attachment #3 and #4).</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A PI monitor of a minimum of weekly random medication pass checks will be performed by the DON and/or MDS coordinator in her absence (see attachment #5) to ensure the implementation of the process of administration of each medication separately as per in-service and policy change (see attachment #3 and #4).</p>	
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F 332	Continued From page 5 revealed the LPN was not aware that medications should be administered separately and the gastrostomy flushed before and after each medication was administered.  An interview conducted with LPN #2 on 08/14/13 at 11:20 AM revealed the LPN was not aware of the standard of practice to administer medication separately and to flush between each medication unless contraindicated. According to LPN #2, she had not had any training at the facility regarding medication administration for residents with gastrostomy tubes.  An interview with the Director of Nursing (DON) on 08/15/13 at 2:45 PM revealed the DON was not aware that medications should be administered separately and flushed before and after administration. Further interview revealed the DON had not monitored nurses administering medications by gastrostomy tube.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	F441  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. During the survey it was found that LPN#2 had contaminated her gloves and did not perform proper changing and proper hand hygiene at the time of contamination and continued to administer medications via G tube. An in-service was provided to all staff on 8/16/2013 (see attachment #6) concerning proper hand hygiene. Also at that time the hand washing/ hand hygiene policy was reviewed (see attachment #7) Staff will continue to follow guidelines for hand hygiene as outline in the in-service (see attachment #3) and by policy (see attachment #7).	9/5/2013

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F 441	<p>Continued From page 6 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to maintain an effective infection control program to help prevent the transmission of disease and infection. Staff failed to change gloves and wash hands after picking up an item from the floor and prior to rearranging resident equipment and administering medications by gastrostomy tube to Resident B.</p> <p>The findings include:  A review of the facility policy titled Guideline for Hand Hygiene (undated) revealed staff was</p>	F 441	<p>Cont F441</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: All resident have the potential to suffer from poor hand hygiene of staff. An in-service was provided to all staff on 8/16/2013 (see attachment #6) concerning proper hand hygiene. Also at that time the hand washing/ hand hygiene policy was reviewed (see attachment #7). Staff will continue to follow guidelines for hand hygiene as outline in the in-service (see attachment #3) and by policy (see attachment #7). A PI monitor of random hand hygiene will be done to ensure proper hand hygiene is being performed at least weekly (see attachment #8).</p> <p>3. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur: An in-service was provided to all staff on 8/16/2013 (see attachment #6) concerning proper hand hygiene. Also at that time the hand washing/ hand hygiene policy was reviewed (see attachment #7). Staff will continue to follow guidelines for hand hygiene as outline in the in-service (see attachment #3) and by policy (see attachment #7). A PI monitor of random hand hygiene will be done to ensure proper hand hygiene is being performed at least weekly (see attachment #8).</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A PI monitor (see attachment #8) will be done with random checks of staff at least weekly. This will be performed and monitored by the DON and the MDS in her absence. This monitor will be done to ensure that proper hand hygiene is being performed by staff providing care to the residents.</p>		

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F 441	<p>Continued From page 7</p> <p>required to decontaminate hands after contact with inanimate objects, including medical equipment, in the immediate vicinity of the resident.</p> <p>Observations conducted during medication administration on 08/14/13 at 10:00 AM revealed Licensed Practical Nurse (LPN) #2 retrieved a piece of paper from the floor with gloved hands, rearranged resident equipment (e.g. a footstool and overbed table), checked placement of Resident B's gastrostomy tube, and administered the resident's medications without changing the contaminated gloves or washing/sanitizing her hands.</p> <p>An interview conducted with LPN #2 on 08/14/13 at 11:15 AM revealed she was nervous because she was being observed and forgot to change her gloves and wash her hands after picking up the piece of paper and rearranging the resident's equipment.</p> <p>A review of documentation of a skills competency observation revealed the facility's Infection Control Nurse observed LPN #2 on 01/23/13 and determined the LPN was competent in the provision of clinical skills.</p> <p>An interview conducted with the facility Infection Control Nurse on 08/15/13 at 2:20 PM revealed she selects staff randomly, on a monthly basis, and observes them for compliance with facility policy and hand hygiene as they provide care to residents. Further interview revealed the Infection Control Nurse had not identified any concerns related to staff, including LPN #2, failing to sanitize their hands and/or to change gloves when indicated.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>WILLIAMSON ARH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503</b>		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval: 1985</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type I (332) Protected</p> <p>Smoke Compartments: Three</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Wet)</p> <p>Generator: Type I Diesel and Type I Natural Gas. Natural Gas was original and Diesel was installed in 1996.</p> <p>A life safety code survey was initiated and concluded on 08/15/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be 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.