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

PRINTED: 06/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/02/2012
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 106 RODGERS PARK CYNTHIANA, KY 41031	

(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 000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 05/30/12 and concluded on 06/02/12. Immediate Jeopardy (IJ) was determined to exist on 04/16/12 at 42 CFR 483.20 Resident Assessment, F-281 and F-282 at a Scope and Severity (S/S) of a "J" and 42 CFR 483.25 Quality of Care, F-333 at a S/S of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. On 04/16/12 the facility failed to ensure staff worked within their scope of practice by allowing Certified Nursing Assistant (CNA) #11, to administer insulin, without verification of the medication type and dosage by a Licensed Nurse. Although the Licensed Nurse, Registered Nurse (RN) #2 was not with CNA #11 when he prepared the insulin for administration, RN #2 was present when CNA #11 administered the incorrect insulin and incorrect dosage to Resident #12. This failure was likely to cause serious injury, harm, impairment or death to a resident. It was determined the facility had completed all corrective action, including revision of their process and staff education by 04/25/12, prior to the State Agency initiating the survey on 05/30/12, thus resulting in the determination of Past Jeopardy.	F 000		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Kentucky Board of Nursing (KBN) statute, review	F 281	RECEIVED JUN 27 BY Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

administrator 6-25-12

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 281	Continued From page 1 of the facility's source of professional standards, "Perry and Potter Clinical Nursing Skills and Techniques 7th Edition", review of the facility's Job Description for Nursing Assistants, and review of the facility's Medication Error Report it was determined the facility failed to ensure professional standards of care and failed to ensure Physician's Orders were followed for one (1) of fourteen (14) sampled residents (Resident #12). The facility failed to ensure professional standards of practice by allowing Certified Nursing Assistant (CNA) #11 to shadow with Registered Nurse (RN) #2. On 04/16/12, CNA #11 prepared Injectable Insulin (medication used to regulate blood sugar for Diabetic patients) without verification of the medication type and dosage by a licensed nurse. Registered Nurse (RN) #2, who was to supervise the CNA who was shadowing her, was aware he had independently drawn up the medication and allowed CNA #11 to administer the medication to Resident #12 without her verification of the correct medication and dosage. The facility failed to ensure Resident #12's Physician's Orders were followed related to Insulin administration. CNA #11 administered Humulin 70/30 Insulin (forty) 40 units on 04/16/12 to Resident #12; however, the order was for Novolin Regular Sliding Scale Insulin two (2) units for a Finger Stick Blood Sugar (FSBS) of 161 on 04/16/12 at 9:05 PM. (Refer to F333) Based on the above findings, it was determined the facility's failure to ensure services provided met professional standards of practice, and the	F 281		

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F 281	Continued From page 2 failure to ensure Physician's Orders were followed was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was determined to exist on 04/16/12. It was determined the facility had completed all corrective action including staff education prior to the survey, thus resulting in Past Jeopardy. The findings include: Record review revealed no evidence the facility ensured staff had access to a specific insulin administration protocol/policy and procedure. Review of the standards of practice source used by the facility, "Perry and Potter Clinical Nursing Skills and Techniques 7th Edition", revealed the following related to insulin administration: the skill of administering subcutaneous injections can not be delegated to a Nurse Applicant, check accuracy and completeness of the Medication Administration Record (MAR), check patient's name, medication name and dosage, and route of administration prior to the administration of insulin. Review of the KBN statute 314.031, revealed unlawful acts related to nursing included practicing nursing without a current active licensure, privilege, or valid temporary work permit issued by the KBN. Review of CNA #11's personnel record revealed he was hired by the facility on 10/26/09 as a Certified Nursing Assistant, and was in nursing school to become a Registered Nurse.	F 281		

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F 281	Continued From page 3 Review of the facility's Nursing Assistant Job Description and Performance Standards, revealed authority was delegated to the individual in this position to provide care to residents following facility policies and procedures and report residents' needs and concerns to a licensed nurse. Further review of the Job Description for a Nursing Assistant revealed no evidence that administration of medications was included. Review of Resident #12's medical record, revealed diagnoses including Chronic Renal Failure requiring Dialysis treatment, and Diabetes Mellitus requiring Finger Sticks four (4) times per day. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/11/12, revealed the facility assessed the resident as severely impaired in cognitive skills for decision making. Review of the Physician's Orders, dated April 2012, revealed orders for Humulin 70/30 Insulin eight (8) units subcutaneous (SQ) at 8:00 AM, and Humulin 70/30 Insulin four (4) units SQ at 4:30 PM, hold if FSBS is less than ninety (90). Further review revealed orders for Novolin R (Regular) SQ at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM with sliding scale as follows: 151-200 equals two (2) units, 201-250 equal four (4) units, 251-300 equals six (6) units, 301-350 equals eight (8) units, 351-400 equals ten (10), 401-450 equals twelve (12) units and call Physician. Review of the facility's Medication Error Report, dated 04/16/12, revealed CNA #11 administered 70/30 Insulin 40 units subcutaneous in error due to looking at the wrong Medication Administration	F 281		

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F 281	Continued From page 4 Record (MAR). Continued review revealed the Physician was notified and CNA #11 was in-serviced on proper drawing up of insulin, reading the MAR, and having insulin verified by another nurse. Review of Resident #12's Nurse's Notes, dated 04/16/12 at 9:05 PM, completed by Registered Nurse (RN) #2, revealed RN #2 was notified at 9:05 PM that a CNA #11 gave the patient the wrong insulin and the wrong dosage. The Note stated the resident received Humulin Insulin 70/30 forty (40) units and should have received Regular Sliding Scale Insulin two (2) units at 8:00 PM. The resident was given four (4) glasses of grape juice and two (2) chocolate chip cookies. The Physician was notified and new Physician's Orders were received. Review of the Physician's Orders, dated 04/16/12 at 10:20 PM, revealed orders to start IV (intravenous) fluids, D5 NS at 50 ml's hr, (5% Dextrose in Normal Saline at fifty milliliters an hour), stop IV fluids after ten (10) hours of infusing, decrease IV fluids to twenty-five (25) ml's per hr if FSBS is greater than 400, check FSBS every two (2)hours while infusing D5NS, call physician if FSBS less than 100, and hold 8 AM insulin on 04/17/12. Continued review of the Nurse's Note revealed Resident #12's FSBS at 10:30 PM was 178. Further review of the Note, revealed the nurse attempted to start an IV twice; however, was unsuccessful. Further review revealed the Physician was paged again at 11:15 PM and returned the call at 11:30 PM with new orders for Glutose fifteen (15) grams every two (2)hours	F 281		

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F 281	Continued From page 5 until FSBS stable, recheck FSBS prior to administration, If FSBS drops seventy (70) or below give Glucagon 1 mg (one milligram)SQ. After giving Glucagon wait one (1) hour, recheck FSBS and if below seventy (70) send to emergency room. Continued review of the Nurse's Note revealed the resident's FSBS at 11:30 PM was 98 and the resident received Glutose 15 grams at 12:00 AM with no signs and symptoms of hypoglycemia. Interview, on 05/30/12 at 5:15 PM and on 06/01/12 at 3:20 PM, with CNA #11 revealed he worked at the facility for three (3) years as a CNA and graduated RN school three (3) weeks ago, receiving an Associate Degree in Nursing. The CNA confirmed the first day he was assigned to shadow a nurse was 04/15/12 and he stated he did not have a provisional RNA at that time. He stated he only followed RN #2 around on 04/15/12 and read facility policies. Continued interview revealed he was not instructed by the Director of Nursing (DON) whether he could or could not administer medications or perform nursing duties and was not instructed on his duties in general during this orientation. He stated the DON told him to follow the head nurse/RN; however, was not specific on what he could and could not do except he was told specifically he could not chart on the residents. Further interview, revealed on 04/16/12 at 8:00 PM, RN #2 was assisting another resident, when Resident #12 requested his/her Insulin. He stated he had been giving insulin while a student at the college and decided to go ahead and administer Resident #12's Insulin. When asked how he had made the mistake of drawing up the incorrect insulin and dosage, CNA #11 explained,	F 281		

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F 281	Continued From page 6 he was looking for the 8:00 PM Insulin on the MAR and flipped the page over to the next resident's MAR without realizing it. He stated this was partly due to there being no separators in the MARs between residents. Continued interview revealed CNA #11 drew up the Insulin for Resident #12 without assistance from a licensed nurse and took the syringe in Resident #12's room to administer the medication. He stated RN #2 was with him when he administered the Insulin to Resident #12; however, the nurse did not verify the medication vial or how much medication was in the syringe. He confirmed RN #2 watched him give Resident #12 the injection. Further interview revealed he was going to sign the MAR after administering the medication when he realized another resident's name was at the bottom of the MAR. Further interview revealed he knew right away he had administered the wrong Insulin type and dose to Resident #12. CNA #11 stated he informed RN #2 he had given the wrong medication and she notified the Physician, and family, and made out a Medication Error Report. CNA #11 stated the Insulin he administered on 04/16/12 to Resident #12 was the only medication he administered. Interview, on 06/01/12 at 10:05 AM, with RN #2 revealed 04/16/12 was the first time CNA #11 was assigned to shadow with her, and when she asked CNA #11 what he was allowed to do, she was informed he could pretty much do everything but chart on the residents. RN #2 confirmed the DON did not tell her specifically what CNA #11 was allowed to do and she was under the assumption he was allowed to administer medications since he was assigned to shadow with her. Continued interview revealed, she was	F 281		

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F 281	Continued From page 7 not with CNA #11 when he drew up the Insulin because she was assisting another resident at the time. However, RN #2 confirmed she was with CNA #11 when he administered the Insulin and did not verify the correct insulin type or dosage. Interview, on 05/31/12 at 7:30 PM and on 06/02/12 at 11:50 AM and 2:10 PM with the Director of Nursing (DON), revealed CNA #11 expressed to her, he was uneasy with his nursing skills and she stated she had been his clinical instructor while he was in nursing school. She stated she decided to let CNA #11 "shadow" the nurses for two (2) weeks prior to receiving his provisional licensure for RNA and she did not expect him to do nursing duties. She stated CNA #11 did not have an assignment during that time but was expected to help the CNA's feed and pass ice, read the facility's policies, and follow the nurses. When the DON was asked what shadowing the nurses entailed, she stated this would include assessing the residents for practice, as long as the licensed nurse also assessed the resident and observing the nurses during nursing procedures. She stated she did not write down what his duties were but thought he understood what he was and was not allowed to do since he did not yet have a provisional license. Further interview revealed CNA #11 worked the second shift and she had verbally informed the second shift nurses that CNA #11 was to shadow them. She stated she specified CNA #11 could not document in the medical records, but failed to specify that he could not administer medications and perform nursing duties because she assumed the nurses knew that. Continued interview verified CNA #11 was	F 281		

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F 281	Continued From page 8 not under a preceptorship at the facility during this time frame from 04/15/12 when he started orientation to shadow the nurses until he received his provisional license on 05/09/12. Interview with the Attending Physician, on 06/02/12 at 11:28 AM, and the Medical Director, on 06/02/12 at 11:37 AM, revealed this Insulin error was a significant medication error because sustained hypoglycemia could have multiple negative effects. Both physicians revealed Resident #12's renal/dialysis status would make it especially difficult for the resident to eliminate the additional Insulin. Interview, on 06/01/12 at 11:10 AM, with the Administrator revealed she had just started at the facility on 05/14/12 and was unaware of CNA #11 administering Insulin prior to her coming there. She stated a CNA should not have been on the medication cart giving Insulin due to the potential for danger. The facility implemented the following actions to correct the deficiency: *RN #2 notified the Physician on 04/16/12 at 10:20 PM of the Insulin medication error for Resident #12 *RN #2 received a Physician's Order on 04/16/12 at 10:20 PM and 11:30 PM related to the Insulin medication error and implemented the Physician's Orders. *Nursing staff monitored Resident #12's Fingerstick Blood Sugars on 04/16/12 at 9:00 PM, 10:30 PM and 11:30 PM and on 04/17/12 at 12:00	F 281		

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F 281	Continued From page 9 AM, 2:00 AM, 4:00 AM and 6:00 AM. *RN #2 completed a Medication Error Report on 04/16/12 related to the Insulin error for Resident #12 which stated CNA #11 had administered the wrong medication and wrong dosage to Resident #12. *Per interview with the DON, on 04/17/12 a verbal inservice to all licensed nurses and to CNA #11, presented by the DON, was conducted explaining the five (5) rights of medication administration and explaining that student nurses, who were not currently with a clinical instructor, and CNA's were not to administer medications. This inservice was not documented with signatures of staff who attended; however, the following staff was interviewed and stated they had received the inservice and were knowledgeable of the information received in the inservice: Licensed Practical Nurse (LPN) #1/Assistant Director of Nursing (ADON)on 06/01/12 at 7:30 PM, LPN #2 on 06/02/12 at 9:10 AM, LPN #3 on 06/02/12 at 5:00 PM, LPN #4 on 06/30/12 at 4:15 PM, LPN #6 on 06/01/12 at 7:30 PM, LPN #7 on 06/01/12 at 12:00 PM, RN #1 on 06/01/12 at 7:15 PM, RN #2 on 06/01/12 at 6:50 PM, RN #5 on 06/01/12 at 5:00 PM, and CNA #11 on 06/01/12 at 3:20 PM. *On 04/20/12 an inservice presented by the DON with signatures of staff including nurses, Kentucky Medication Aides (KMA's), Social Service Director, and CNA #11 which stated the following areas of instructions were covered: five (5) rights related to medication administration, holes in MAR's and Treatment Administration Records (TAR's), following up on pain medication and anxiety medication, and the pain scale.	F 281		

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F 281	Continued From page 10 Review of the facility's documentation verified that all staff had received the inservice. *A Quality Assurance Meeting was held on 04/25/12 at which the Insulin medication error related to Resident #12 was discussed according to the interview with the Medical Director on 6/02/12 at 11:37 AM. A copy of the QA Meeting signatures for the staff who attended the meeting on 04/25/12 was reviewed which included the Medical Director. *Interview, on 06/01/12 at 3:20 PM, with CNA #11 revealed he was inserved independently on 04/16/12 by the DON and also with the group on 04/17/12 regarding the five (5) Rights of medication administration and that CNA's could not adminsiter medications. Interview, on 06/01/12 at 12:00 PM, with LPN #7/QA Nurse revealed they had monthly QA Meetings in which the Department Heads and Medical Director attended. She stated at the end of the month she checked the MAR's and TAR's and did a graph related to areas such as falls, infections, and medication errors. She confirmed the incident related to Resident #12 receiving the incorrect insulin and dosage was discussed in QA. Interview, on 06/01/12 at 2:10 PM, with the DON revealed she would never let another CNA who had not yet received a provisional licensure "shadow" with a licensed nurse. She further stated if a student nurse was coming to the facility to work they would need to be with their clinical instructor or be in a preceptorship at the facility. She stated her system to ensure correct	F 281		

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F 281	Continued From page 11 supervision of staff was to make out the schedule herself. She further stated the Assistant Director of Nursing (ADON) was at the facility until 6:00 PM most days to assist with supervising. She stated she randomly looked at the MAR's and TAR's for documentation and any type of error such as sliding scale amounts administered and LPN #7/QA Nurse checked the MARs and TARs on a regular basis. Further interview revealed medication errors were kept in a book and each medication error was followed up on immediately and taken to the next QA meeting for discussion.	F 281		
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's standards of practice source "Perry and Potter Clinical Nursing Skills and Techniques 7th Edition", and review of the facility's Medication Error Report, it was determined the facility failed to ensure it was free of significant medication errors for one (1) of fourteen (14) sampled residents (Resident #12). Resident #12 received Humulin 70/30 Insulin (forty) 40 units; however was ordered Novolin Regular Sliding Scale Insulin two (2) units for a Finger Stick Blood Sugar (FSBS) of 161. On 04/16/12 at 9:05 PM, the incorrect type and dosage of insulin was administered by a Certified Nursing Assistant (CNA) who was not working within his scope of practice. (Refer to F-281)	F 333	Past noncompliance: no plan of correction required.	

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F 333	Continued From page 12 The CNA was assigned to "shadow" a nurse on 04/16/12. The nurse, the CNA was assigned to shadow, was not present when the medication was prepared by the CNA to be administered to Resident #12; however, the nurse was present at the time of the injection and allowed the CNA to administer the medication without her verification of correct drug and dosage. Based on the above findings, it was determined the facility's failure to ensure it was free of significant medication errors was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 04/16/12. It was determined the facility had completed all corrective action including a change in the facility's process and staff education prior to the Survey, thus resulting in Past Jeopardy. The findings include: The facility failed to provide a specific Insulin administration protocol/policy and procedure. Review of the standard of practice source used by the facility, "Perry and Potter Clinical Nursing Skills and Techniques 7th Edition", revealed prior to administration of Insulin the nurse should check accuracy and completeness of the Medication Administration Record (MAR), check the patient's name, medication name and dosage, and route of administration. Further review revealed the skill of administering subcutaneous injections can not be delegated to a Nurse Applicant. Review of the facility's Medication Error Report,	F 333		

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	185332		06/02/2012

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F 333	Continued From page 13 dated 04/16/12, revealed Resident #12 received 70/30 Insulin 40 units subcutaneous in error due CNA #11 looking at the wrong Medication Administration Record (MAR). Further review revealed the Physician was notified and CNA #11 was in-serviced on proper drawing up of insulin, reading the MAR, and having insulin verified by another nurse. Review of Resident #12's medical record, revealed diagnoses which included Chronic Renal Failure with Dialysis treatment three (3) times per week and Diabetes Mellitus requiring Finger Sticks four (4) times per day. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/11/12, revealed the facility assessed the resident as severely impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as receiving Insulin the past seven (7) days. Review of the Physician's Orders, dated April 2012, revealed orders for Humulin 70/30 Insulin eight (8) units subcutaneous (SQ) at 8:00 AM, and Humulin 70/30 Insulin four (4) units SQ at 4:30 PM, hold if FSBS is less than ninety (90). Further review revealed orders for Novolin R (Regular) SQ at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM with sliding scale as follows: 151-200 equals two (2) units, 201-250 equal four (4) units, 251-300 equals six (6) units, 301-350 equals eight (8) units, 351-400 equals ten (10), 401-450 equals twelve (12) units and call Physician.' Review of Resident #12's Nurse's Notes, dated 04/16/12 at 9:05 PM, completed by Registered	F 333		

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F 333	Continued From page 14 Nurse (RN) #2 revealed RN #2 was notified at 9:05 PM that a CNA #11 gave Resident #12 the wrong Insulin and the wrong dosage. The resident received Humulin Insulin 70/30 forty (40) units and should have received Regular Sliding Scale Insulin two (2) units at 8:00 PM. Further review revealed the resident was given four (4) glasses of grape juice and two (2) chocolate chip cookies. According to the Note the Physician was paged and returned the call with new Physician Orders. The resident's FSBS at 10:30 PM was 178. Further review of the Note, revealed the nurse attempted to start an IV (Intravenous) two (2) times and was unsuccessful. The Note stated the Physician was paged again at 11:15 PM and returned the call at 11:30 PM with new orders. Continued review revealed the resident's FSBS at 11:30 PM was 98 and the resident received Glutose 15 grams at 12:00 AM with no signs and symptoms of hypoglycemia. Review of the Physician's Orders, dated 04/16/12 at 10:20 PM, revealed orders to start IV (intravenous) fluids, D5 NS at 50 ml's hr, (5% Dextrose in Normal Saline at fifty milliliters an hour), stop IV fluids after ten (10) hours of infusing, decrease IV fluids to twenty-five (25) ml's per hr if FSBS is greater than 400, check FSBS every two (2) hours while infusing D5NS, call physician if FSBS less than 100, and hold 8 AM Insulin on 04/17/12 Continued review of Physician's Orders, dated 04/16/12 at 11:30 PM, revealed orders for Glutose fifteen (15) grams every two (2) hours until FSBS stable, recheck FSBS prior to administration, If FSBS drops seventy (70) or	F 333		

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F 333	Continued From page 15 below give Glucagon 1 mg (one milligram) SQ. After giving Glucagon wait one (1) hour, recheck FSBS and if below seventy (70) send to emergency room. Interview, on 05/30/12 at 5:15 PM and on 06/01/12 at 3:20 PM, with CNA #11 revealed he worked at the facility for three (3) years as a CNA and had graduated RN school three (3) weeks ago with an Associate Degree in Nursing. He stated the first day he worked at the facility to "shadow" a nurse was 04/15/12 and he did not have a provisional RNA at that time. He further stated he just followed RN #2 around on 04/15/12 and read policies. Continued interview revealed he was not informed whether he could or could not administer medications and was not instructed on his duties in general during this orientation. He further stated the Director of Nursing (DON) said to follow the head nurse/RN and was not specific on what he could and could not do. Further interview revealed on 04/16/12 at 8:00 PM RN #2 was assisting a resident who was having Asthma symptoms when Resident #12 asked for his/her Insulin. He stated he was looking for the 8:00 PM Insulin on the MAR and flipped the page over to the next resident's MAR without realizing it because there were no separators in the MAR between residents. He further stated he drew up the Insulin for Resident #12 and took the syringe into Resident #12's room to administer the medication. CNA #11 stated RN #2 was with him when he gave the Insulin to the resident and did not verify the medication vial or how much medication was in the syringe; however, she did watch the injection being administered. Further interview revealed he was going to sign the MAR after administering	F 333		

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F 333	Continued From page 16 the medication and realized there was another resident's name was at the bottom of the MAR, and he knew right away he had administered the wrong Insulin type and dose to Resident #12. CNA #11 stated RN #2 was there with him when he realized he had given the wrong medication and she notified the Physician, and family, and made out a Medicine Error Report. He confirmed the insulin he administered on 04/16/12 to Resident #12 was the only medication he administered. Interview, on 06/01/12 at 10:05 AM, with RN #2 revealed 04/16/12 was the first time CNA #11 was assigned to "shadow" her, and when she asked CNA #11 what he was allowed to do, he told her he could do pretty much everything. RN #2 stated the Director of Nursing (DON) did not tell her specifically what CNA #11 was allowed to do and she was therefore under the assumption he was allowed to administer medications since he was assigned to shadow with her. She further stated, she was not with CNA #11 when he prepared the Insulin because she was assisting another resident. However, she confirmed she was with the CNA when he administered the Insulin. Interview, on 06/31/12 at 7:30 PM and on 06/02/12 at 11:50 AM and 2:10 PM, with the DON, revealed CNA #11 was to shadow the nurses for two (2) weeks prior to receiving his provisional licensure for RNA and she did not expect him to do nursing duties. When asked what shadowing the nurses entailed, she stated this included assessing the residents as long as the licensed nurse also assessed the resident and observing the nurses during nursing.	F 333		

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F 333	Continued From page 17 procedures. Continued interview revealed she had verbally in-serviced the second shift nurses and specified CNA #11 was to shadow them. She stated she specified he could not document in the medical records, but failed to specify that he could not administer medications and perform nursing duties because she assumed the nurses knew that. Interview with the Attending Physician, on 06/02/12 at 11:28 AM, revealed this was a significant medication error because sustained hypoglycemia could have multiple negative effects. He further stated the resident's dialysis status would make it especially difficult for him/her to eliminate the additional insulin. Continued interview revealed he was notified of the medication error and gave orders for repeat FSBS through the night and to transfer to the emergency room for intravenous fluids. Interview with the Medical Director, on 06/02/12 at 11:37 AM, revealed this was a significant medication error because a high dose of Insulin could cause hypoglycemia with multiple effects of hypoglycemia on the resident. Continued interview revealed the dose to be significantly dangerous based on the resident's diagnosis of renal failure because he/she could note eliminate the Insulin except at dialysis. He further stated the incident was brought up at the Quality Assurance Meeting and decisions were made to ensure the appropriate staff administered medications. Interview, on 06/01/12 at 11:10 AM, with the Administrator revealed she had just started at the facility on 05/14/12 and was unaware of CNA #11	F 333		

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F 333	Continued From page 18 administering Insulin prior to her coming there. She stated a CNA should not have been on the medication cart giving insulin due to the potential for danger. The facility implemented the following actions to correct the deficiency: *RN #2 notified the Physician on 04/16/12 at 10:20 PM of the Insulin medication error for Resident #12 *RN #2 received a Physician's Order on 04/16/12 at 10:20 PM and 11:30 PM related to the Insulin medication error and implemented the Physician's Orders. *Nursing staff monitored Resident #12's Fingerstick Blood Sugars on 04/16/12 at 9:00 PM, 10:30 PM and 11:30 PM and on 04/17/12 at 12:00 AM, 2:00 AM, 4:00 AM and 6:00 AM. *RN #2 completed a Medication Error Report on 04/16/12 related to the Insulin error for Resident #12 which stated CNA #11 had administered the wrong medication and wrong dosage to Resident #12. *Per interview with the DON, on 04/17/12 a verbal inservice to all licensed nurses and to CNA #11, presented by the DON, was conducted explaining the five (5) rights of medication administration and explaining that student nurses, who were not currently with a clinical instructor, and CNA's were not to administer medications. This inservice was not documented with signatures of staff who attended; however, the following staff was interviewed and stated they had received the	F 333		

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F 333	Continued From page 19 inservice and were knowledgeable of the information received in the inservice: Licensed Practical Nurse (LPN) #1/Assistant Director of Nursing (ADON)on 06/01/12 at 7:30 PM, LPN #2 on 06/02/12 at 9:10 AM, LPN #3 on 06/02/12 at 5:00 PM, LPN #4 on 05/30/12 at 4:15 PM, LPN #6 on 06/01/12 at 7:30 PM, LPN #7 on 06/01/12 at 12:00 PM, RN #1 on 06/01/12 at 7:15 PM, RN #2 on 06/01/12 at 6:50 PM, RN #5 on 06/01/12 at 5:00 PM, and CNA #11 on 06/01/12 at 3:20 PM. *On 04/20/12 an inservice presented by the DON with signatures of staff including nurses, Kentucky Medication Aides (KMA's), Social Service Director, and CNA #11 which stated the following areas of instructions were covered: five (5) rights related to medication administration, holes in MAR's and Treatment Administration Records (TAR's), following up on pain medication and anxiety medication, and the pain scale. Review of the facility's documentation verified that all staff had received the inservice. *A Quality Assurance Meeting was held on 04/25/12 at which the Insulin medication error related to Resident #12 was discussed according to the interview with the Medical Director on 6/02/12 at 11:37 AM. A copy of the QA Meeting signatures for the staff who attended the meeting on 04/25/12 was reviewed which included the Medical Director. *Interview, on 06/01/12 at 3:20 PM, with CNA #11 revealed he was inserved independently on 04/16/12 by the DON and also with the group on 04/17/12 regarding the five (5) rights of medication administration and that CNA's could not administer medications.	F 333		

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F 333	Continued From page 20 Interview, on 06/01/12 at 12:00 PM, with LPN #7/QA Nurse revealed they had monthly QA Meetings in which the Department Heads and Medical Director attended. She stated at the end of the month she checked the MAR's and TAR's and did a graph related to areas such as falls, infections, and medication errors. She confirmed the incident related to Resident #12 receiving the incorrect insulin and dosage was discussed in QA. Interview, on 06/01/12 at 2:10 PM, with the DON revealed she would never let another CNA who had not yet received a provisional licensure "shadow" with a licensed nurse. She further stated if a student nurse was coming to the facility to work they would need to be with their clinical instructor or be in a preceptorship at the facility. She stated her system to ensure correct supervision of staff was to make out the schedule herself. She further stated the Assistant Director of Nursing (ADON) was at the facility until 6:00 PM most days to assist with supervising. She stated she randomly looked at the MAR's and TAR's for documentation and any type of error such as sliding scale amounts administered and LPN #7/QA Nurse checked the MARs and TARs on a regular basis. Further interview revealed medication errors were kept in a book and each medication error was followed up on immediately and taken to the next QA meeting for discussion.	F 333	**Preparation and execution of this plan of correction does not constitute an admission of 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 Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 21 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure that an account of all controlled drugs were maintained and reconciled. Observation of the narcotic	F 431	**F431 D Storage and Labeling Drugs and Biologicals** **Targeted Residents** There was no targeted resident identified. Employee #1, #2, and #3 received counseling regarding documentation of administration of medications and correctly counting and documenting narcotics on 5-30-12 **Identification of Other Residents** All residents have the potential to be affected. On 6-11-2012 a thorough review of all medication storage areas was completed by a pharmacy representative to ensure proper narcotics accounting for, no concerns were identified by the pharmacy representative. An additional review was completed on 6/19/12 by the Quality Assurance Nurse and the Staff Development Coordinator with no concern noted in this review	

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F 431	Continued From page 22 count, on 05/30/12 at 5:20 PM, revealed there was a discrepancy in the amount of Cheratussin AC Syrup (narcotic cough medication) in the bottle as compared with the Controlled Drug Record for one (1) unsampled resident (Unsampled Resident C). The findings include: Review of the facility's policy, "Preparation and General Guidelines", undated, revealed "medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. When a controlled medication is administered, the licensed nurse administering the medication or staff member lawfully authorized to administer medications and who administered the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): date and time of administration, amount administered, signature of the nurse administering the dose, completed after the medication is actually administered". Observation of the narcotic count, on 05/30/12 at 5:20 PM, revealed a bottle of Cheratussin AC Syrup had approximately twenty-four (24) milliliters (ml) of liquid and review of the Controlled Drug Record indicated there was thirty (30) ml of the medication left in the bottle. Further review of the Controlled Drug Record and review of the 05/12 Physician's Orders for Unsampled Resident C, revealed orders for	F 431	**Systemic Changes** Individual and group in-servicing has been completed with licensed nurses, licensed nurse applicants, and Kentucky Medication Aides on policies, procedures for documenting and counting scheduled medications. In-services were initiated on 5-30-12 and were completed on 6-25-12. In-services were completed by the Staff Development Coordinator, DON, and ADON. Medication administration skills validation checks were completed by the Staff Development Coordinator and were completed on 6-25-12. The Quality Assurance (QA) Nurse or Staff Development Coordinator will continue with audits of narcotic records and skills validation checks on licensed nurses and Kentucky Medication Aides weekly for four weeks and monthly thereafter.	

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F 431	Continued From page 23 Cheratussin AC Syrup five (5) milliliters (ml's) by mouth for chronic cough. Interview, on 05/30/12 at 5:25 PM, with Kentucky Medication Aide (KMA) #1 revealed she had counted with Registered Nurse (RN) #2 at the change of shift that morning and did not realize the count was off. Observation revealed she was attempting to count the liquid by holding the bottle in her hand. She stated since she was coming on shift she counted the medication and the nurse going off shift was to look at the Controlled Drug Record. Interview, on 05/30/12 at 5:30 PM, with Licensed Practical Nurse (LPN) #3 revealed she had worked the evening of 05/29/12 and administered the medication, five (5) milliliters at 8:00 PM to Unsampled Resident C and forgot to sign it out on the Controlled Drug Record. Interview, on 05/31/12 at 7:30 PM, with the Director of Nursing (DON) revealed the staff was to place liquid medications at eye level in order to have a correct count. She confirmed the staff who was leaving the medication cart for the night shift on 05/29/12 and the staff taking over the medication cart for the day shift on 05/30/12 should have caught the discrepancy in the narcotic count and the liquid medication.	F 431	**Monitoring** The results of the narcotic record reviews and nursing skills validations will be submitted to the Quality Assurance Committee for review and further recommendations as needed.	6/27/2012
F 441 SS=E	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.	F 441	**F441 D Infection Control** **Targeted Residents** Skin assessments were completed by an RN and an LPN for Residents #2, #3, #4, #5, #7, #8, and Residents D and E on 6-19-12. These residents exhibited no signs or symptoms of infection and no change in status.	

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F 441	Continued From page 24 (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 actions related to infections. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to establish and	F 441	**Identification of Other Residents** All residents have the potential to be affected. Infection control rounds were made by the Registered Nurse Consultant throughout the facility, including medication storage room, on 6/19/2012 to identify any possible infection control concerns. Any areas noted were addressed immediately. A thorough review of all medication storage areas was completed by a pharmacy representative to ensure proper storage and labeling of storage of emergency medication box, cups, and food and/or drinks utilized for medication pass, no concerns were noted in this review. The Staff Development Coordinator completed finger stick skills validation checks on all licensed nurses and licensed nurse applicants on 6-14-12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	106 RODGERS PARK CYNTHIANA, KY 41031

(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 441	Continued From page 25 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 for six (6) of fourteen (14) sampled residents (Resident's #2, #4, #5, #7, #8, #3) and two (2) unsampled residents (Unsampled Residents D and E). Observation of a fingerstick blood sugar for Unsampled Residents D and E, revealed an Registered Nurse Applicant (RNA) failed to clean the sites with an Alcohol pad prior to performing the finger sticks. Observation of a skin assessment and dressing changes for Resident #3, and observations of skin assessments for Resident's #8, #4, #7, #2, #5 revealed poor infection control technique. Observation of the medication room revealed four (4) containers of applesauce which had expired, a clear container of orange fluid with no label or date, a box of medication cups sitting directly on the floor and an emergency tackle box sitting directly on the floor. The findings include: Review of the facility's policy titled "Infection Control Program Overview", dated 2007, revealed staff and resident education focuses on risk of infection and practices to decrease risk. It continued to state policies, procedures and aseptic practices are followed by personnel in performing procedures. 1. Review of the facility's "Fingerstick Blood Sugar" Policy, undated, revealed the procedure	F 441	**Systemic Changes** Individual and group in-servicing has been completed with licensed nurses and licensed nurse applicants on infection control policies, procedures, prevention, and techniques. In-services were initiated on 6-6-12 and will be continued through 6-26-12. In-services and skills validations were completed by the Staff Development Coordinator and a Pharmacy Representative. The Quality Assurance (QA) Nurse or nurse manager will make daily infection control rounds using a rounds checklist. The Staff Development Coordinator will continue skills validation checks on licensed nurses weekly for 4 weeks and monthly thereafter.	

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	185332		06/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	105 RODGERS PARK CYNTHIANA, KY 41031

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F 441	Continued From page 26 Included: wash hands and apply gloves, explain the procedure to the resident, insert the test strip and wait for the flashing blood drop to appear, swap the tip of the resident's finger with the alcohol pad, allow to dry, and prick the finger with the lancet. Observation, on 05/30/12 at 4:00 PM, revealed RNA #1 carried supplies into Unsampled Resident D's room including the glucometer, lancets, and test strips; however, there was no observation of alcohol pads with the supplies. He then proceeded to obtain a fingerstick blood sugar for Unsampled Resident D; however, did not clean the resident's finger with an alcohol pad prior to the finger stick. Licensed Practical Nurse (LPN) #4 was with RNA #1 during the procedure and did not comment. Further observation, on 05/30/12 at 4:15 PM, revealed RNA #1 carried supplies into Unsampled Resident E's room including the glucometer, lancets, and test strips; however, there was no observation of alcohol pads with the supplies. He then proceeded to obtain a fingerstick blood sugar for Unsampled Resident E without cleaning the resident's finger with an alcohol pad prior to the procedure. LPN #4 was with RNA #1 during the procedure and again did not instruct RNA #1 on the need to clean the site with a alcohol pad prior to performing the fingerstick. Interview, on 05/30/12 at 4:15 PM, with LPN #4 revealed she did not notice that RNA #1 did not clean the residents' fingers with an alcohol pad prior to performing the fingerstick blood sugars. She stated she was to observe RNA #1 for all procedures including finger sticks, administration	F 441	**Monitoring** The results of the infection control rounds and the nursing skills validation will be submitted to the Quality Assurance Committee for review and further recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/02/2012
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 106 RODGERS PARK CYNTHIANA, KY 41031	

(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 441	Continued From page 27 of medications, assessments, and documentation; however, she did not usually supervise RNA #1 because he normally worked evening shift. Interview, on 05/30/12 at 5:00 PM, with RNA #1 revealed he was currently working in the capacity of an RNA and was to follow the nurses and perform administration of medications, and perform treatments. He further stated he was usually supervised by an RN. He stated he must have been nervous; however, knew he was to clean the site prior to performing a finger stick. Interview, on 05/31/12 at 7:30 PM, with the Director of Nursing (DON) revealed per the facility's policy, staff were to use alcohol pads to clean the site prior to performing a finger stick. She further stated, the LPN supervising RNA #1 should have caught this. 2. Review of the facility's policy titled "Special Procedures Changing of Wound Dressings", not dated, revealed the procedure was to include putting on gloves then removing the old dressing, cleansing the area, removing gloves and placing them in the bag with the soiled dressing. It further stated hands should be washed between glove changes and then clean gloves should be donned before applying prescribed medication, ointment or creams. However, the policy did not state hand sanitation method after the point of applying and securing the dressing. Observation of a skin assessment and dressing change for Resident #3, on 05/31/12 at 6:30 PM, revealed LPN #8 removed the soiled dressings from the resident's left medial first (1st) toe	F 441		

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F 441	Continued From page 28 wound and the resident's right lateral ankle wound and placed the soiled scissors in her pocket, and then on the resident's bedside table. She then proceeded with the same soiled gloves and measured both wounds with the same measuring tape by placing the tape over the wounds (the tape was touching the wounds). Further observation revealed she then removed her soiled gloves and washed her hands. LPN #8 then applied sure prep to the left medial 1st toe wound, applied a foam dressing, and kerlex. She then applied sure prep to the right lateral ankle wound, applied a foam dressing, and applied kerlex. The nurse then, with the same soiled gloves, pulled up the resident's covers, used the remote control to lower the bed, pulled the bedside curtain, and removed the soiled gloves and washed her hands. Interview with LPN #8, on 06/31/12 at 7:00 PM, revealed she should not have placed the soiled scissors in her pocket or on the bedside table without a barrier. She further stated she should have washed her hands after removing the soiled dressings and should not have touched both wounds with the same measuring tape. Continued interview revealed she should have changed gloves and washed hands between measuring wounds and performing dressing changes to the wounds. The LPN acknowledged she had applied the dressings to the resident's lower extremities and failed to remove the soiled gloves and wash her hands before touching objects in the room. 3. Observation, on 05/31/12 at 10:28 AM, of Resident #7's skin assessment performed by the	F 441		

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F 441	Continued From page 29 Wound Care Nurse revealed the nurse started at the resident's head. The Wound Care Nurse proceeded down the front of the resident's body, pulled Resident #7's pants down and started assessing the perineal area. The nurse touched the resident's perineal area, then proceeded to assist the resident in turning over without changing her gloves and sanitizing her hands. The Wound Care Nurse touched Resident #7's back and buttocks, then continued down the resident's body touching the legs and feet. The nurse pulled the resident's pants up, adjusted the bed covers, and pushed the privacy curtain back before removing her gloves. 4. Observation, on 05/31/12 at 10:48 AM, of Resident #2's skin assessment performed by the Wound Care Nurse revealed the nurse initiated the assessment at the resident's head. The Wound Care Nurse continued to assess the front of the resident's body. She pulled Resident #2's slacks down and assessed the resident's perineal area, touching the perineal area with her gloved hands. The nurse did not remove her gloves or sanitize her hands. She assisted the resident to turn and assessed Resident #2's back and buttock area, then moved to the resident's legs and feet. She pulled Resident #2's slacks up, adjusted the covers on the bed, and pushed the privacy curtain back without removing her gloves and sanitizing her hands. Interview, on 05/31/12 at 7:12 PM, with the Wound Care Nurse revealed she should have removed her gloves and sanitized her hands after assessing Resident #2 and Resident #7's perineal areas and buttock areas.	F 441		

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F 441	Continued From page 30 5. Observation of a skin assessment for Resident #4 on, 05/31/12 at 5:45 PM, revealed LPN #8, after she assessed the resident's perineal area, the LPN failed to remove the contaminated gloves she was wearing, wash her hands and don clean gloves prior to continuing the skin assessment. She again, failed to remove the contaminated gloves, wash her hands and don clean gloves after the LPN assessed the resident's buttocks and sacral areas, prior to assisting Resident #4 to get dressed. 6. Observation of a skin assessment for Resident #5, on 05/31/12 at 11:17 AM, revealed LPN #8, after she assessed the resident's perineal area, the LPN failed to remove the contaminated gloves she was wearing, wash her hands and don clean gloves prior to continuing the skin assessment. The LPN, again, failed to remove the contaminated gloves, wash her hands and don clean gloves after she assessed the resident's buttocks and sacral areas, prior to assisting Resident #5 to get dressed. 7. Observation of a skin assessment for Resident #8, on 05/31/12 at 6:00 PM, revealed LPN #8, after she assessed the resident's perineal area, the LPN failed to remove the contaminated gloves she was wearing, wash her hands and don clean gloves prior to continuing the skin assessment. The LPN, again, failed to remove the contaminated gloves, wash her hands and don clean gloves after she assessed the resident's buttocks and sacral areas, prior to assisting Resident #8 to get dressed.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	186332		06/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	106 RODGERS PARK CYNTHIANA, KY 41031

(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 441	Continued From page 31 Interview, on 06/02/12 at 12:30 PM, with LPN #8 revealed she should have washed her hands and changed her gloves after the perineal area assessment and the buttock and sacral area assessments. She stated she didn't realize that she failed to change gloves and wash her hands, she did not think about it. Further interview revealed she had inservices on handwashing and infection control. Interview, on 06/02/12 at 11:57 AM, with the Assistant Director of Nursing (ADON) revealed LPN #8 should have removed the gloves after the assessment to the perineal area and the resident's buttocks, washed her hands and donned clean gloves before touching another area on the resident's body. She further stated the staff had just received an inservice on handwashing. Interview, on 06/02/12 at 12:50, with the Director of Nursing (DON) revealed gloves should be changed after they were soiled from the perineal area and other dirty areas during a skin assessment. 8. Observation of the medication room, on 05/30/12 at 12:45 PM, revealed four (4) containers of applesauce which had expiration date of 05/29/12, a clear container of orange fluid (fifteen ounces) with no label or date, a box of medication cups sitting directly on the floor and an emergency tackle box sitting directly on the floor. Interview with Registered Nurse (RN) #8, on 05/30/12 at 12:45 PM, who was in the medication room at the time, revealed the applesauce was	F 441		

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	185332	A. BUILDING B. WING	06/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	106 RODGERS PARK CYNTHIANA, KY 41031

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F 441	Continued From page 32 outdated and needed to be thrown away, and the orange juice needed to be labeled and dated when placed in the container. She further stated the box of medication cups as well as the emergency tackle box should not be on the floor. Continued interview revealed the emergency tackle box was always there in the floor and she did not know where else it would fit in the room. Interview, on 05/31/12 at 7:30 PM, with the DON, revealed she did not see anything wrong with having the medication cups in the floor since they were in sleeves and did not see a problem with having the emergency box in the floor.	F 441		6/27/2012

Acceptable date 6/27/12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	186332		05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	105 RODGERS PARK CYNTHIANA, KY 41031

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1979 Facility type: SNF/NF Type of structure: One story, Type V (unprotected) Smoke Compartment: Four (4) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, single station smoke detectors installed in resident rooms 102, 103, 106, 107, 109, 203, 204, 209, and 210 New panel installed 2005. Sprinkler System: Complete sprinkler system (dry). New dry pipe valve installed 11/15/11 Generator: Type 2 generator powered by natural gas A Standard Life Safety Code Survey was conducted on 05/30/12. Grand Haven Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was fifty one (51). The facility is licensed for fifty four (54) beds. The Highest Scope and Severity deficiency was	K 000	**Preparation and execution of this plan of correction does not constitute an admission of 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 Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	administrator	6-25-12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 B. WING	06/31/2012

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

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K 000	Continued From page 1 an "F" level.	K 000	**K 025 (F) Smoke Barriers**	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, fifty four (54) residents, staff and visitors. The findings include: Observation, on 05/30/2012 at 10:24 AM, revealed the smoke barrier for the 100 Hall, had unsealed penetrations around the sprinkler piping and an electrical junction box. Further observation revealed the smoke barrier wall for the 200 Hall had unsealed penetrations around the sprinkler piping and a data wire. The Dining Room smoke barrier had unsealed penetrations around electrical conduit. Penetrations in smoke	K 025	**Targeted Residents** There were no targeted residents identified. **Identification of Other Residents** All residents have the potential to be affected. On 6/22/12, an audit of all rooms and common areas in facility were completed to ensure that there were no additional unsealed penetrations around sprinkler piping, electrical junction boxes, data wire and electrical conduit in dining room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	

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K 025	Continued From page 2 barriers must be sealed to prevent the spread of smoke during a fire. The observations were confirmed with the Maintenance Director. Interview, on 05/30/2012 at 10:24 AM, with the Maintenance Director, revealed he had recently sealed several penetrations in the smoke barriers but was unaware he had missed the other penetrations. Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.	K 025	**Systemic Changes** Maintenance director began initiating sealing of smoke penetrations in building on 5/31/12. Sealants were reviewed and completed 6/15/12 by Maintenance Director. Adequately sealed smoke penetrations have been added to environmental rounds on 6/20/12. These observations will be made using the rounds checklist and will continue on a weekly basis. Any identified unsealed penetrations will be repaired immediately. **Monitoring** The results of the environmental rounds will be submitted to the quarterly safety meeting for review and further recommendations as needed.	

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

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	

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K 025	Continued From page 3 b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		6/27/2012
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access, was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty four (54) residents, staff and visitors. The findings include: Observation, on 05/31/12 at 10:28 AM, revealed one door of the front door set would not open fully due to hitting the overhead canopy. The	K 038	**K 038 (F) Exit Access** **Targeted Residents** There were no targeted residents identified. **Identification of Other Residents** All residents have the potential to be affected. **Systemic Changes** Maintenance Director obtained outside contractor to complete repair of exit access door. Repair of front door set that did not previously open fully due to hitting overhead canopy was completed 6/14/12. Exit access doors have been added to existing safety committee rounds on 6/20/12. These observations will be made using rounds checklist and will be completed monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/31/2012
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 106 RODGERS PARK CYNTHIANA, KY 41031	

(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 038	Continued From page 4 observation was confirmed with the Maintenance Director. Reference: NFPA 101 (2000 edition) 7.2.1.4.1* Any door in a means of egress shall be of the sidehinged or pivoted-swinging type. The door shall be designed and installed so that it is capable of swinging from any position to the full required width of the opening in which it is installed.	K 038	**Monitoring** The results of all exit access door rounds will be submitted to quarterly safety meetings for review and further recommendations as needed with the upcoming meeting to be held 6/26/12 where life safety code deficiencies will be reviewed.	6/27/2012
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained free and clear of obstruction, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments; fifty-four (54) residents, staff and visitors. The findings include: Observation, from 05/30/12 9:30 Am until 11:05	K 072	**K 072 (F) Exits Free and Clear of Obstruction** **Targeted Residents** There were no targeted residents identified. **Identification of Other Residents** All residents have the potential to be affected. **Systemic Changes** Individual in-servicing has been completed with all staff on ensuring that exits are maintained free and clear of obstruction. In-services were initiated 6/5/12 and completed 6/15/12. In-services were completed by staff development coordinator.	

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	186332	A. BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER
GRAND HAVEN NURSING HOME

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K 072	Continued From page 5 AM, revealed wheel chairs, patient lifts, and soiled linen carts were left unattended and not in use longer than thirty (30) minutes on both the 100 and 200 Halls. The observation was confirmed with the Maintenance Director. Corridors cannot be used to store items due to the area being used as an exit during an emergency. Interview, on 05/30/12 at 11:35 AM, with the Maintenance Director, revealed items were routinely stored in the corridors. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Facility initiated continuous quality improvement (CQI) rounds which are completed daily, Monday through Friday, that include assurance of exits being maintained free and clear of obstruction. Rounds initiated 6/12/12 and continue on a daily basis. **Monitoring** The daily CQI rounds will be submitted to the CQI Committee that meets daily (M-F) for recommendations and follow up.	6/27/2012
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure single station smoke detectors were inspected, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect two (2) of four (4) smoke compartments, eighteen (18) residents, staff and visitors. The findings include:	K 130	**K 130 (E) Single Station Smoke Detectors** **Targeted Residents** Rooms 102, 103, 105, 106, 107, 108, 109, 203, 204, 209, and 210 **Identification of other residents** All residents in the listed rooms have the potential to be affected as well as facility's entire resident population.	

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	

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K 130	Continued From page 6 Observation, on 05/30/12 at 10:52 AM, revealed resident rooms 102, 103, 105, 106, 107, 108, 109, 203, 204, 209 and 210 contained single station smoke detectors. Single station smoke detectors visible to the public must be inspected and maintained to ensure their reliability. The observation was confirmed with the Maintenance Director. Interview, on 05/30/2012 at 11:36 AM, with the Maintenance Director revealed he did not inspect the single station smoke detectors, but believed an outside contractor did. Record review, on 05/30/12 at 11:36 AM, of the quarterly fire alarm inspections from an outside contractor, revealed no documented evidence the single station smoke detectors had been inspected. The record review was confirmed with the Maintenance Director. Reference: NFPA 101 (2000 edition) 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. Reference: NFPA 72 (1999 edition) 7-3.3 Single station smoke detectors installed in one- and twofamily dwelling units shall be inspected, tested, and maintained as specified in Chapter 8. Single station detectors installed in other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7.	K 130	**Systemic Changes** Single station smoke detectors that were identified were removed as it was determined they were not needed since the facility presently has adequate fire/smoke protection coverage. Single station smoke detectors were removed 5/30/12. On 6-22-12, an audit of all rooms in facility were completed to ensure that there were no additional single station smoke detectors present that had not yet been identified. **Monitoring** There will be no need to monitor any single station smoke detectors since the facility removed them on 5/30/2012 and the facility has adequate fire/smoke protection coverage.	6/27/2012

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	186332	A. BUILDING 01 B. WING	05/31/2012

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K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring and electrical components were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, ten (10) residents, staff and visitors. The findings include: Observation, on 05/30/2012 at 10:32 AM, revealed two electrical junction boxes were missing covers. Further observation revealed in the generator transfer switch room, boxes were being stored in front of electrical panels. Electrical junction boxes must be covered to prevent fires and electrical shock. Storage cannot be located in front, above or to the sides of electrical panels due to fire risk. The observations were confirmed with the Maintenance Director. Interview, on 05/30/2012 at 10:32 AM, with the Maintenance Director, revealed he was unaware of the missing electrical covers for the two (2) junction boxes. Further interview revealed the Maintenance Director had warned staff about storing items in front of the electrical panels.	K 147	**K 147 (D) Electrical Wiring and Equipment** **Targeted Residents** There were no targeted residents identified. **Identification of Other Residents** All residents have the potential to be affected by K 147. **Systemic Changes** Boxes were removed from site of storage in front of electrical panels 6/8/12 and placed in alternative storage unit on facility property. Shelving unit that had been previously used to store items was removed 6/8/12. In addition, electrical junction boxes were covered 6/8/12 to prevent fires and electrical shock.	

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

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K 147	Continued From page 8 Reference: NFPA 70 (1999 edition) 110-26 Spaces Sufficient access and working space shall be provided and maintained around all electrical to permit ready and safe operation and maintenance of such equipment.	K 147	Electrical junction boxes as well as ensuring that storage in front of electrical panels remains absent have been added to existing safety committee rounds on 6/20/12. These observations will be made using a rounds checklist to be completed monthly. Any identified concerns will be corrected immediately. **Monitoring** The results of the safety committee rounds will be submitted to the quarterly safety meetings for review and further recommendations as needed with the upcoming meeting to be held 6/26/12 where life safety code deficiencies will be reviewed.	6/27/2012