

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

PRINTED: 10/08/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2010
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 279	Continued From page 20 the wound and determined the wound was not healed. LPN #3 stated she contacted the physician's office and obtained an order to continue the Granulex soaks, but did not complete a wound assessment or update the care plan. Review of the skin problem care plan confirmed that the care plan had not been revised to include the wound status or the physician's order for treatment. Further interview with the DON revealed the wound assessment and care plan revision should have been completed, and documented.  3. Medical record review revealed Resident #10 was admitted on 05/18/10 with diagnoses of Alzheimer's, Dementia, Macular degeneration, High Blood Pressure, Hypothyroidism, Peripheral Vascular Disease, Syncope, Stress Incontinence, Constipation, Abnormal Gait, and a surgical knee replacement. Review of the Admission MDS Assessment dated 05/25/10 revealed vision and cognitive needs were triggered on the RAP's. Review of the comprehensive care plan dated 05/25/10 revealed no evidence that the facility had developed a care plan to address the residents vision and cognitive deficits.  Interview with the Director of Social Services, on 09/23/10 at 1:30pm, revealed when the care plan was reviewed, there were no measurable objectives for vision or cognitive needs included in Resident #10's comprehensive care plan.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	Resident #1's chart was audited to ensure that MD orders had been transcribed correctly.  On 10-14-10 nurses were in-serviced on protocol having 2 nurses to verify	10-26-10



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F 309	Continued From page 21 accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide necessary care and services to maintain the highest practicable physical, mental, and psychosocial well being for one (1) of twenty-seven (27) sampled residents. Resident #1 did not receive a prescribed medication (Lisinopril) for eight (8) days after admission related to a transcription error.  The findings include:  Review of the facility policy for Admission of the Resident revealed to utilize the Admission form, admission orders, and call and verify orders with the facility attending Physician. The facility policy for Transcribing Physician Orders revealed all nurses are responsible for transcribing any orders they take off during the month, to the unsigned recert orders.  Review of the medical record for Resident #1 revealed an admission date of 03/03/10 with diagnoses including Late Effect Hemiplegia related to Cerebral Vascular Accident, Hypertension, Atrial Fibrillation, Bladder Disorder, Diabetes Mellitus, and Urinary Trach Infection.  Resident #1 was admitted with Physician orders for Lisinopril 20mg one tablet every day. Lisinopril (lyse IN oh pril) is an ACE inhibitor. This medicine is used to treat high blood pressure and	F 309	orders have been transcribed correctly to medication administration records/treatment administration records.  On all new/readmits the Unit Coordinators will bring the charts to morning meeting with DON/ADON to audit for proper transcription of orders.  Any concerns identified during the reviews will be immediately addressed as appropriate. The results of the audit will be reviewed by the QA committee quarterly.	

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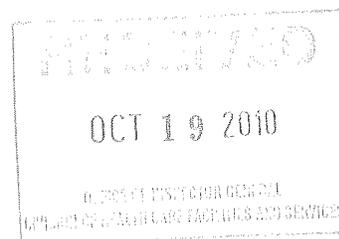
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F 309	Continued From page 22 heart failure.(information for Drugs.com). Review of the admission medication administration record (MAR) revealed the order for Lisinopril was not transcribed until 03/10/10. Resident # 1 did not receive the first dose until 03/11/10.  Interview with Licensed Practical Nurse #6 revealed she was the nurse that admitted Resident #1 on 03/03/10. She stated she had worked at the facility for two years. LPN #6 stated she had faxed the orders to pharmacy, then transcribed the orders to the physician orders, then to the MAR. She stated they usually have another nurse to verify the transcription, and thinks it was the facility policy to have another nurse to verify. She stated it was a very difficult night, and that a family member was constantly interrupting during the night of the admission. LPN #6 stated no one else verified the transcription of the physician orders and that's why the error occurred.  Review of the nurses notes on 03/10/10 revealed the Physician was notified and the medication was ordered on 03/10/10. Review of the blood pressure record for Resident #1 revealed blood pressures were obtained from 03/03/10 to 03/11/10 and recorded at the lowest 118/72 to 180/90 at the highest. There was no documented injury to the resident and the resident did not require any medical intervention.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	F 314 Resident #13's wound assessment was completed, physician was notified and treatment was initiated. The care plan has been revised to reflect the wound status and interventions. Resident # 13's daily activities and functions have not been affected by his wound.	10-26-10

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COMMONWEALTH OF KENTUCKY

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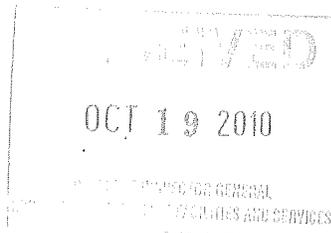
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F 314	<p>Continued From page 23</p> <p>individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to promote healing of pressure ulcer for one (1) of twenty-seven (27) sampled residents (#13). The facility failed to complete a physician ordered wound assessment and failed to report the status of the wound to the physician for Resident #13.</p> <p>The findings include:</p> <p>Record review of the Pressure Ulcer policy dated 01/01/09 revealed the purpose is to promote the prevention of pressure ulcer development and promote the healing of pressure ulcers.</p> <p>Record review of the Physician orders found an order dated 08/25/10 to continue Granulex soak to open area on left heel twice daily for 14 days, then re-evaluate.</p> <p>Record review of the medication record found Granulex soaks were discontinued on 09/09/10, by an automatic stop order (ASO).</p> <p>Record review of Nurses's notes revealed no wound assessment documented on 09/09/10 for Resident #13 and no documentation to indicate physician was notified of wound status on 09/09/10.</p>	F 314	<p>Skin assessments are completed weekly on all residents.</p> <p>Nurses were re-educated on Skin Care Program and wound assessment and revision of care plans to reflect status of skin and current interventions by Deloris Jacobs, DON on 10-14-10.</p> <p>The Unit Coordinators and DON/ADON will audit 25 charts weekly for appropriate care planning and interventions for 90 days and review their results with the QA Committee quarterly.</p>	



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F 314	<p>Continued From page 24</p> <p>Record review of Physician orders and Nurse's notes found the order dated 09/22/10 to 'continue Granulex soak to open area on left heel twice daily for 14 days, then re-evaluate', and Nurse's note to continue same treatment. Documentation did not include wound assessment or report of assessment communicated to physician.</p> <p>Observation on 09/23/10 at 9:40am of wound treatment for Resident #13, performed by LPN #2, revealed an open wound on the resident's left heel, described by LPN #2 as pink tissue, with no drainage. Wound treatment provided was Granulex soak.</p> <p>Interview on 09/22/10 at 10:00am with LPN #3 regarding left heel wound care for Resident #13 revealed the wound was healed, and the treatment was discontinued on 09/09/10.</p> <p>Interview on 09/23/10 at 10:00am with LPN #2 revealed a wound assessment should have been documented in the Nurse's notes when the order was obtained to continue the Granulex soak treatments. LPN #2 was not able to locate a wound assessment in the chart.</p> <p>Interview on 09/24/10 at 11:00am with LPN #3 and the Director of Nursing (DON) revealed that LPN #3 decided to consult the DON on 09/22/10 regarding the wound status. The DON assessed the wound and found dry skin or a scab which she removed, revealing the wound was not healed as previously documented and she advised LPN #3 to notify the physician to obtain an order to continue the prior treatment. LPN #3 said she called the physician and obtained an order to continue the Granulex soak treatments. LPN #3 said she did not document a wound</p>	F 314		



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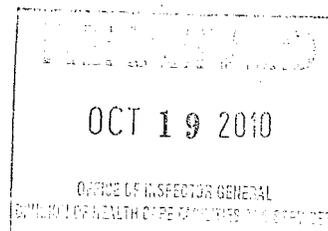
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F 314	Continued From page 25 assessment or communicate the findings of the assessment to the physician. The DON said the wound should have been assessed, measured, and documented in the chart, adding documentation is necessary to demonstrate progressive healing of the wound.	F 314	F 323 Resident #23 is no longer at the facility.	10-26-10
F 323 SS=C	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and assistive devices to prevent accidents for one of twenty-seven (27) sampled residents. The facility failed to conduct a thorough investigation and assessment which resulted in the facility's failure to develop and implement effective interventions to prevent accidents for Resident #23. Resident #23 complained of left knee pain on 03/01/10 after Resident #23's left leg got caught under the wheelchair during staff transport. On 03/12/10, Resident #23 sustained a fracture of the left femur when Resident #23's left leg got caught under the wheelchair while facility staff transported the resident a second time.  The findings include:	F 323	The DON/ADON and unit managers will review the past 90 days of incidents to ensure that facility protocol was followed and appropriate interventions were put in place.  Licensed staff are being re-educated on 10-19-10 by DON/ADON regarding incident protocol and determining root cause to ensure that interventions are appropriate.  The therapy manager attends the daily department manager morning meeting and communicates pertinent therapy information/ observations to key personnel to ensure that changes are communicated to the appropriate personnel. The nursing and therapy departments also utilize Ans-R-Gram's for more immediate notification between therapy and nursing. Nurses and therapy personnel are being in-serviced by Deloris Jacobs, DON and Monica Gahagan, Therapy Manager regarding proper utilization of Ans-R-Gram's.  Unit Coordinators will audit the Ans-R-Grams and incidents to ensure appropriate follow thru. Findings will be reviewed with the DON/ADON during morning meeting.  DON/ADON will meet with Unit Managers weekly to audit incidents and care plans to ensure that interventions are in place then forward to the Administrator. Unit Coordinators will submit findings to the QA Committee.	



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F 323	<p>Continued From page 26</p> <p>Review of the closed medical record for Resident #23 revealed an admission date of 02/09/10 with diagnoses including Heart Valve Replacement, Old Myocardial Infarction, Congestive Heart Failure, history of old left knee replacement, and rehab. Review of the 02/09/10 Nursing Admission Assessment revealed the facility assessed Resident #23 as having partial loss of range of motion of the knee, limited to one side. Review of the 2/16/10 Admission Minimum Data Set(MDS) assessment revealed the facility assessed the resident as having no cognitive difficulties, independent with bed mobility, requiring two person extensive physical assistance, one person assistance and supervision needed with ambulation, and no limitation with range of motion. Review of the Resident Assessment Protocol Summary (RAPS) dated 02/16/10 for ADL functional/Rehabilitation potential revealed Resident #23 used a wheelchair for long distance as the resident "tires" easily. Resident #23 was documented as able to assist in activities, but not able to complete tasks alone. On 02/17/10, the facility care planned Resident #23 for ADL Functional/Rehabilitation because the resident needed extensive assistance with bed mobility and transfers.</p> <p>Review of the 03/02/10 Physical Therapy Notes revealed the "patient reports that the left foot got caught under the chair yesterday as it was being pushed and the left knee flexed beyond ninety degrees. Nursing reports patient has been cleared to continue physical therapy today. Patients left lower extremity exhibits pitiable edema from foot to six inches above the knee. An interview with Physical Therapy Assistant (PTA), on 09/23/10 at 10:38am, revealed she documented the note on 03/02/10 that Resident</p>	F 323		

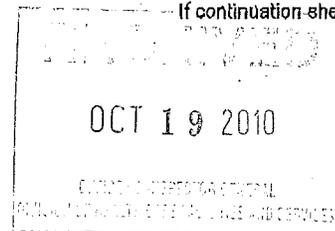
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F 323	<p>Continued From page 27</p> <p>#23 got the foot caught under the wheelchair the previous day. The PTA stated the resident told her that a male "aide" had pushed her the night before in the wheelchair and the resident got his/her left leg caught. On 03/02/10 Resident #23 complained of pain when the PTA got the resident up to ambulate. The PTA stated she retrieved the nurse that was providing care for the resident, the nurse assessed the resident and cleared the resident for Therapy.</p> <p>Interview with Registered Nurse #1 on 09/23/10 at 1:20pm revealed she was the nurse working on the 3-11 shift on 03/01/10 when Resident #23 had the first incident. She stated she didn't get any report of a possible injury to Resident #23. She stated Resident # 23 had complained of pain and swelling of the left knee on the evening of 03/01/10 and that she assessed the leg for injury but didn't think anything was wrong. She stated she did not call the Physician because she didn't know of any incident/injury, and didn't think there was an injury. An interview with the Rehab Manager, on 09/22/10 at 9:15am, revealed she did recall a previous incident in which Resident #23 was in a wheelchair being pushed by staff, and the left leg dropped down, but she did not recall that it caused an injury. Interviews with Licensed Practical Nurse #5 (assigned to Resident #23 on 03/01/10), on 09/24/10 at 10:30am, with LPN #4, on 09/24/10 at 10:00am, and with the Director of Nursing (DON), on 09/24/10 at 11:30am, revealed they had no knowledge of the 03/01/10 incident where Resident #23 got his/her foot caught under the wheelchair. Furthermore, there was no evidence that the facility investigated to identify the causal factors of the resident's complaint of pain to the knee or the swelling which was noted by RN#1 on</p>	F 323		



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F 323	<p>Continued From page 28</p> <p>03/01/10. Additionally, there is no evidence that the facility developed or implemented care plan interventions to prevent the recurrence of the resident's foot getting caught under the wheelchair.</p> <p>Review of the nurses notes, dated 03/12/10 at 12:45pm, revealed Resident #23 was being wheeled up the hallway by the Therapy Tech #2. The left leg dug under the wheelchair and the resident and the Therapy Tech heard a pop sound from the left knee. Facility staff placed Resident #23 in bed and applied ice to the knee. Resident #23 was sent to the hospital for an x-ray of the left knee. The x-ray confirmed the fracture of the left femur.</p> <p>Interview with Therapy Tech #2, on 09/23/10 at 9:53am, revealed she was the Tech that was transporting Resident #23 on 03/12/10 when the resident sustained the fracture. She stated that Resident #23 would usually walk down to therapy but that the resident had not been feeling well the past couple of days, so she transported the resident in a wheelchair. The Tech stated that the resident propelled him/herself, but became tired so the Tech pushed the wheel chair for the resident. The Tech stated the resident's foot dropped, and that's when she heard the pop. The Tech stated she was not aware Resident #23 had a previous left knee replacement or that the resident had a previous similar incident where the left leg dropped and got caught under the wheelchair.</p> <p>Interview with Certified Nursing Asslstant (CNA) #4, on 09/22/10 at 12:00pm, revealed she took care of Resident #23 regularly. The CNA stated that Therapy did take the resident in a wheelchair</p>	F 323			

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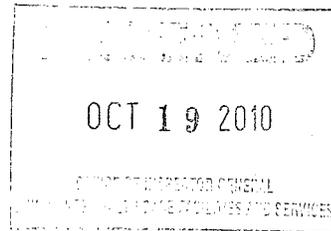
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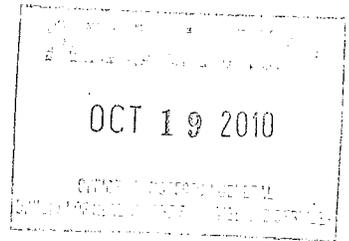
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F 323	<p>Continued From page 29</p> <p>without foot rests. CNA #4 stated that it depended on how the resident felt for the day if the resident could hold his/her feet up. She stated that just before the resident had the fracture, the resident had a decline. CNA #4 stated that she would have put foot rests on the wheelchair for Resident #23 if she was transporting the resident because Resident #23 was short of air and would get tired very easily.</p> <p>An Interview with Physical Therapy Assistant (PTA) on 09/23/10 at 10:38am revealed if she was pushing Resident #23 in the wheelchair, she would have put leg rests on the chair. She stated that would have been her standard of practice.</p> <p>An interview with the Rehab Manager, on 09/22/10 at 9:15am, revealed it was a standard of practice that if a resident has underlying conditions, staff should put leg rests on the resident's wheelchair. The Rehab Manager stated that looking back now, Resident #23 should have had leg rests on the wheelchair during transport.</p> <p>Further interview with the Director of Nursing (DON) revealed while not knowing of the previous report of an injury that occurred on 03/01/10 prior to the fracture that occurred on 03/12/10 she stated that facility staff should have conducted a more thorough assessment of Resident #23.</p> <p>While the facility implemented a policy dated 03/17/10 that any resident that is transported via wheelchair by therapy staff must have appropriate leg rests on the wheelchair; the facility could provide no evidence that interventions had been developed and implemented prior to the incident on 03/12/10 when Resident #23 sustained a fractured left femur after staff transported the</p>	F 323		



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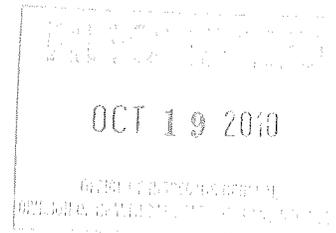
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2010
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 323 F 325 SS=D	Continued From page 30 resident a second time without leg rests. 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 maintain acceptable parameters of nutritional status for one (1) of twenty-seven (27) sampled residents. Resident #3 had inadequate nutritional status as indicated by weight loss, inaccurate documentation of food intake, and the inability to formulate an effective nutritional plan to ensure caloric needs were met.  The findings include:  Observation on 09/21/10 at 1:00pm of Resident #3 eating in the dining room, unassisted, using a scoop plate, revealed the resident ate quickly with jerky movements, large amounts of food dropped to the floor and on the resident's clothing protector.  Observation on 09/22/10 at 1:00pm of Resident	F 323 F 325	F 325 Resident # 3 was reviewed by the dietitian on 9-24-10 and new orders were received from the physician to meet the needs of the resident. Nursing assistants were in-serviced on proper documentation of intake on 9-28-10. Resident # 3 is on weekly weights to monitor for weight loss.  ADON/Unit Managers will audit all residents for the last 3 months to identify any resident who has had a significant weight loss by 10-22-10.  Unit Managers will monitor weekly weights for any significant changes and report changes to the DON/ADON, Dietitian and physician. Unit Managers will follow recommendations from dietitian and obtain orders as needed.  DON/ADON will audit monthly weights on all residents for significant weight changes and ensure that recommendations from dietitian and physician are followed. Results will be reported to the QA Committee quarterly.	10-26-10



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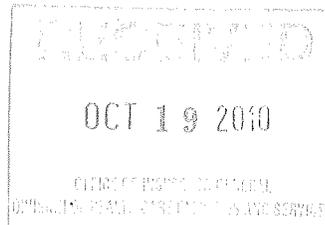
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/24/2010
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F 325	<p>Continued From page 31</p> <p>#3 eating in dining room, unassisted, using a scoop plate and spoon, revealed the resident consumed 50% of his/her meal with the remainder of food having fallen on the clothing protector and in the resident's lap.</p> <p>Observation on 09/23/10 at 1:10pm of Resident #3 found the resident fed by CNA #10, who stated she was told to feed Resident #3 today, by LPN #2 because the resident had some trouble eating for the last week and dropped food on the floor.</p> <p>Record review of the Weights Detail Report for Resident #3 showed a six (6) month weight loss from 04/09/10 through 09/20/10 of seventeen (17) pounds which was an 11.2% decline in body weight.</p> <p>Record review of the Meal Intake Report revealed lunch meal intakes for Resident #3 from 09/01/10 through 09/23/10 averaged ninety-two percent (92%). Lunch meal intake on 09/21/10 was documented as seventy-five percent (75%). Lunch meal intake on 09/22/10 was documented as one hundred percent (100%).</p> <p>Record review on 09/23/10 of the Nutrition Assessment dated 09/14/10 revealed documentation of a 3.1% weight loss in one month and an 11.2% weight loss over six (6) months. Feeding ability was documented as limited assist with scoop plate. Summary included note: "excellent meal intakes, improved; weight loss noted." Nutritional Intervention was stated as "clarify diet texture, fortified foods."</p> <p>Record review on 09/24/10 of Nutritionally at Risk (NAR) Resident Worksheet for Resident #3 shows weekly documentation of meal intakes</p>	F 325			



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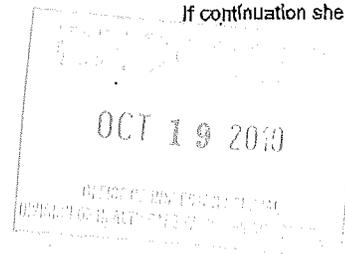
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F 325	<p>Continued From page 32</p> <p>greater than ninety percent (90%) for the month of September, 2010. Note dated 09/06/10 indicates two (2) pound weight loss, and continued weight loss noted on NAR dated 09/10/10, 09/13/10, and 09/20/10, no dietary recommendations noted.</p> <p>During an interview on 09/23/10 at 2:35pm with LPN #2 regarding Resident #3's nutritional and feeding status, LPN #2 stated, "we always feed" him/her. LPN #2 stated Resident #3 is fed by staff because he/she has an acute illness and weight loss, and "I really don't know when we started feeding" him/her and stated she did not direct the CNA to feed Resident #3 at lunch.</p> <p>Interview on 09/23/10 at 3:00pm with the Director of Nursing (DON) regarding the feeding status of Resident #3 revealed the DON suggested staff feed Resident #3 lunch because the surveyors were watching.</p> <p>Interview on 09/24/10 at 9:50am with the Registered Dietician (RD) by phone regarding nutritional and feeding status of Resident #3 revealed the documented intakes from nursing are utilized to develop the nutritional assessment. The RD stated the resident intakes have been poor mostly due to refusal of meals. The RD stated the resident had not been self-feeding and the CNA assistance was likely provided to assist to feed or offer encouragement to feed. The RD stated intakes were documented as improved on the recent Nutrition Assessment and NAR, but observation found Resident #3 consumed half of a meal with the remainder falling to the floor or on the clothing protector, though the documentation indicated one hundred percent (100%) intake as no food was left on the tray. The RD stated it did</p>	F 325		



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F 325	Continued From page 33	F 325		
F 441 SS=E	seem like they told her the resident was wearing a lot of the food. 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 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.	F 441	F 441  DON in-serviced all staff on 9-28-10 and again on 10-18-10 regarding infection control as it relates to not touching food with bare hands.  All residents who receive a po diet have the potential to be affected.  Disposable gloves are located in all resident dining areas and on all meal carts. A meal service audit tool will be completed by DON or designees daily for 2 weeks, 5 days a week for 2 weeks, a minimum of 3 times a week for 30 days and randomly thereafter. Any identified concerns will be addressed immediately.  Results of this audit will be submitted for review by the QA Committee quarterly.	10-26-10



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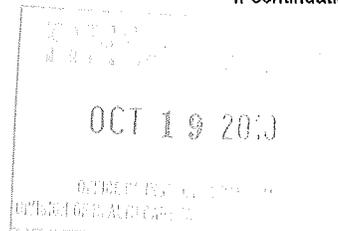
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F 441	Continued From page 34  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to utilize sanitary techniques for assisting residents during two meal observations. Staff were observed touching residents' food with bare hands during breakfast and lunch meal service.  The findings include:  Review of the facility policy on Infection Control did not address the issue of bare hand contact with food.  Observation of breakfast on 09/21/10 at 8:05am on the West Hall revealed that Certified Nursing Assistant (CNA) #1 picked up an unsampled resident's toast with bare hands to spread jelly on it for the resident. She was then observed holding the toast with bare hands while feeding it to the resident.  Interview with CNA #1 on 09/24/10 at 11:45am revealed she had worked at the facility for four days. When asked about the process and her responsibility for setting up meals for residents she stated she sanitizes her hands, takes off lids, makes sure the food is within reach of the residents, and assists with condiments and feeding or cutting up foods. When asked about ready to eat foods such as bread or sandwiches she stated she just pulls it out of the wrapper for the resident if they are unable to do it themselves. She further stated she just uses bare hands. She also stated that she was taught at other facilities	F 441			



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F 441	<p>Continued From page 35</p> <p>where she has worked to wear gloves if touching a resident's food, but at this facility she has not been taught to do that. When asked about training she had received, she stated she was trained by watching other aides. When questioned about why it was not okay to touch the resident's food with bare hands, she responded that germs could be transferred to the resident causing illness.</p> <p>Observation of lunch on 09/22/10 at 12:30pm in the dining/sun room revealed CNA #8 took garlic bread out of its wrapper with bare hands for an unsampled resident. CNA #8 was also observed in the East Dining Room at 1:00pm holding another unsampled resident's garlic bread with bare hands while buttering it for the resident.</p> <p>Interview with CNA #8 on 09/24/10 at 11:00am revealed her responsibility and the process for setting up meals for residents. She stated that her hands are sanitized, the tray is taken to the resident, lids taken off of food and drinks, assistance provided with condiments, checking if diet is correct according to the tray card, and feeding the resident if they cannot feed themself. When questioned about ready to eat foods and how to handle them she stated that she takes it out of the wrapper for the resident if they cannot do that themself. When asked if she normally used her bare hands, as she was observed doing, she responded that she did. She further stated touching food with bare hands can spread germs and also because of common courtesy. She stated she was not aware that she was not supposed to touch the bread. She confirmed that CNA inservices and meetings are done weekly but she did not recall being taught not to touch ready to eat foods with bare hands as long as</p>	F 441		



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F 441	Continued From page 36 hands were sanitized.	F 441			

OCT 19 2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/22/2010
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NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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K 000	INITIAL COMMENTS  A Life Safety Code survey was Inlated and concluded on September 22, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000	Facility Administrator states that the plan of correction contained here-in constitutes the facilities allegation of compliance with all deficiencies cited, that no separate notification of compliance is required by virtue of this allegation of compliance, and that this allegation of compliance may presume the facility's compliance until substantiated by a revisit or other means.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey on 9/22/2010, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards.  The findings include:  Observation during the tour of the buiding on 9/22/2010 from 11:15 AM through 1:00 PM with the Maintenance Staff, revealed nine (9) resident rooms with hanging decorations on the doors. The resident rooms were numbered 207, 310, 500, 501, 502, 506, 9-W, 602 and 609.  Interview with the Maintenance Staff on 9/22/2010 at 11:15 AM, revealed that they were unaware of the requirement that these decorations had to be treated for flame retardant.  NFPA Standard NFPA 101.2000 Edition 19. 7. 5. 4 Combustible decorations shall be prohibited in any health care occupancy unless they are	K 073	K 073 Hanging door decorations on the doors of resident room numbers, 207, 310, 500, 501, 502,506, 9-W, 602 and 609 were treated with fire retardant spray.  The entire facility was audited and the audit revealed 11 other rooms with decorations hanging on the doors. The newly identified 11 other rooms with decorations were also treated on 9-24-10.  The Maintenance Director or his designee will keep a log of decorations treated with fire retardant.  The Maintenance Director or his designee will audit the facility and fire retardant log to ensure that all items are treated and logged. The results of the audit will be brought to the QA Committee for their review.	10-26-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X8) DATE *10-18-10*

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

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K 073	Continued From page 1 flame-retardant.	K 073		

