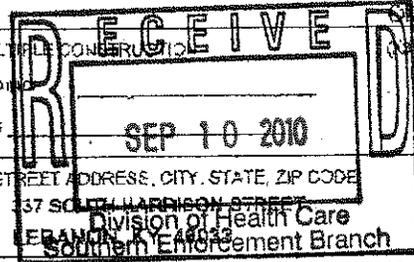


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 37 SOUTH HARRISON STREET LEBANON, KY 40023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC 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 health survey was conducted on August 17-19, 2010. Deficient practice was identified with the highest scope and severity at "F" level. An abbreviated standard survey (KY15144) was also conducted at this time. The allegation was unsubstantiated.	F 000	STATEMENT: The preparation and execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F 164 SS=	483.10(e), 483.76(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164 F-164	1. It is the policy and culture of this facility to provide for the personal privacy for all the residents of Cedars of Lebanon Nursing Center. Privacy was provided immediately for RSD #1 by securing the appropriate enclosures around RSD #1. LPN #1 was immediately counseled regarding the inappropriate actions taken in the care of RSD#1(See Exhibit #1, Copy of Counseling) 2. After review of all residents who have the need for ADL assistance and/or medical treatments the Interdisciplinary Team made the determination that all residents were at risk for the potential loss of privacy from this practice. 3. All staff were re - educated through the use of an inservice conducted on 09/03/10, which detailed the proper procedure for providing privacy, maintaining dignity, understanding the needs of residents while performing care for a resident in their environment.(See Exhibit # 2, Inservice) 4. A quality instrument will be utilized by the Charge Nurse to evaluate resident privacy considerations by the staff while performing care. The monitor will include assuring	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Robbie Eastman* TITLE: *Administrator* (SEE) DATE: *09/10/10*

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 60 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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NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 357 SOUTH HARRISON STREET LEBANON, KY 40033		
(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) COMPLETE ON DATE	
F 184	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide one (1) of seventeen (17) residents (resident #1) with the right to personal privacy. The facility failed to prevent unnecessary exposure of the resident's body during provision of wound care. The findings include: During the initial tour of the facility conducted on August 17, 2010, between 10:55 a.m. and 11:40 a.m., resident #1 was observed lying in bed in the resident's room on his/her right side. Licensed Practical Nurse (LPN) #1 was observed performing wound care for resident #1. The privacy curtain between resident #1 and the resident's roommate remained open during the procedure allowing exposure of resident #1's lower body to the roommate. Interview conducted on August 17, 2010, at 4:10 p.m., with LPN #1 revealed the privacy curtain was left open between resident #1 and the roommate during the wound care procedure and resident #1's lower body was exposed to the roommate during the procedure. LPN #1 further stated resident #1 was not provided personal privacy during the procedure because the privacy curtain was not closed. Interview conducted on August 17, 2010, at 11:40 a.m., with the Registered Nurse Unit Manager of the Raley Hall revealed the privacy curtain should have been closed to provide for personal privacy for resident #1 when the resident was exposed during wound care.	F 184	E-164 Continued that privacy curtains are pulled together appropriately doors are closed and that levels of communication are appropriate (See Exhibit # 3, See Exhibit #2). If there are any indications that a residents privacy may be jeopardized the charge nurse will remind and provide appropriate one on one education with staff member before an incident occurs. The Director of Nurses, Assistant Director of Nurses or Administrator will receive the quality forms weekly for evaluation and review with the Administrator. This process will continue on a daily basis for the period of one month, longer if less than 100% compliance is met. The quality evaluation will continue to be performed five times per week at random by the Director of Nursing or Assistant Director of Nursing for the period of not less than one month until 100 % compliance is maintained. Social services will then poll five random residents to monitor dignity and privacy, until 100% compliance is verified by 30 days on one to one level (See Exhibit # 4-See Exhibit #2, Social Service Privacy Monitor) and report findings to the Quality Assurance Committee for determination if further action plans are needed.	09/03/10	

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F 248 SS-B	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure an ongoing program of activities was provided. There was no evidence the facility provided activities during weekends to meet resident needs in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of each resident.</p> <p>The findings include:</p> <p>A review of the Activities Calendar for the month of July and August 2010 revealed Saturday activities included morning TV and bingo scheduled at 2:00 p.m., and Sunday activities revealed church scheduled at 2:00 p.m.</p> <p>An interview with the Activities Director (AD) on August 18, 2010, at 4:12 p.m., revealed the activities assistant "got tired" around the end of June 2010. She stated the only activity on Saturday was bingo, which was conducted every other Saturday by a volunteer, and the other Saturday by a CNA. The AD stated there was no staff on duty on Sundays. She stated the only activity on Sunday was church and this was provided by different churches that volunteered. The AD revealed if a resident didn't like bingo on</p>	F 248	<p>F-248</p> <ol style="list-style-type: none"> All residents were affected by the practice. The Activities Director was counseled and re educated to the needs of the residents(See Exhibit # 5, Counseling form) to maintain open communication with nursing to ensure resident needs are being met. Residents activities needs were met by the incorporation of weekend activities with the facilities Level II restorative program. Since activities is one of the most important functions for every resident the practice is deemed to have affected all residents. Cedars of Lebanon maintains a Level I, Level II and Level III restorative Program. Weekend activities will be provided in conjunction with the Level II Restorative Programs. The level II Restorative Program has minimal participants which allows for several hours of downtime which will be utilized for those weekend days that were lacking in activities staff. New and varied activities will be offered to residents. These staff members will be specifically scheduled to perform as activities personnel. Activity Director will provide a detailed quality monitor to the Administrator listing type and number of activities with the number residents participating weekly for 3 months then monthly, including weekends which will be reported to the Quality Assurance Committee for review and recommendations.(See Exhibit # 6 , Quality Monitor.) 		09/10/10

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F 248	Continued From page 3 Saturday or church on Sunday there would be nothing else for the resident to participate in.	F 248			
F 281 SS=D	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 observations, interviews, and record reviews, it was determined the facility failed to ensure staff followed physician's orders for two (2) of sixteen (16) sampled residents and one (1) unsampled resident. Resident #17 had a physician's order to receive medication after meals. Staff was observed to administer the medication one (1) hour prior to the resident's meal time. Residents #3 and #10 had a physician's order to receive ice cream with meals to increase the resident's calorie count. The residents did not receive ice cream at meals during the survey. The findings include: 1. Review of the physician's orders for resident #17 dated August 1, 2010, and the Medication Administration Record (MAR) revealed the resident was to receive one packet of Prevalite after meals to treat diarrhea. Review of the meal times for resident #17 revealed the resident's evening meal was scheduled for 5:00 p.m. Observations of medication administration on August 17, 2010, on the Raley Hall revealed the Licensed Practical Nurse (LPN) prepared the medications for resident #17. The LPN	F 281	F-281 1. Resident #17 was assessed for any adverse affects of the deficient practice. Medication administration record was immediately adjusted to reflect the appropriate schedule for the medication. The Physician was notified of the medication administration error, no new orders were received. Nurse responsible for the medication administration was counseled and re-educated at that time.(See Exhibit # 7,counseling form) Resident #3 and Resident #10 were offered ice cream immediately. 2. The Interdisciplinary Team reviewed the current physicians orders to reveal any other residents that may have had medications and or additional dietary orders. There were no other discrepencies discovered other than residents #3,#10,#17. 3. Resident #3 a system evaluation by The IDT determined that current system of tray delivery lead to the practice related to ice cream. The ice cream was being delivered seperately from the regular tray. The process was modified to include the ice cream on the tray in a bowl of ice chips so that when the tray is inspected by the SRNA for accuracy against the tray tag that is by verified by the Dietary manager or Assistant Dietary Manager. Tray tag quality checks are performed to ensure Physician ordered items are present before leaving the kitchen.		

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F 281 Continued From page 4
administered Prevalite one packet mixed in a cup of water at 4:00 p.m.

Interview on August 17, 2010, at 4:00 p.m., with the LPN who had administered medications to resident #17 revealed the resident had not received the evening meal prior to administration of the medication. The LPN was aware the MAR stated the medication was to be given after meals; however, the LPN stated the time on the MAR was 4:00 p.m. and the LPN had given the medication in accordance with the time on the MAR, not after meals as stated in the physician's order.

An interview on August 18, 2010, at 3:25 p.m., with the facility Pharmacist revealed if a medication was specifically ordered to be given after meals, the pharmacy would put the proper time on the MAR unless facility staff had designated a different time when the order was sent to the pharmacy. According to the Pharmacist, the facility had entered the 4:00 p.m. time when the order was sent to the pharmacy to be filled.

2. Resident #3 was admitted to the facility on December 31, 2008, with medical diagnoses to include Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anemia, and Depression.

A Registered Dietitian progress note dated August 18, 2010, summarized resident #3's weight loss and detailed recommendations for weight loss prevention. The progress note revealed on July 23, 2010, the resident weighed 103.8 pounds and ice cream was recommended on July 28, 2010, to increase the resident's caloric

F 281 F - 281 Continued.

Resident #10, a system evaluation by IDT determined that current system of tray delivery lead to the practice related to ice cream. The ice cream was being delivered separately from the regular tray. The process was modified to include the ice cream on the tray in a bowl of ice chips so that when the tray is inspected by the SRNA for accuracy against the tray tag that is by verified by the Dietary manager or Assistant Dietary Manager. Tray tag quality checks are performed to ensure Physician ordered items are present before leaving the kitchen. (See Exhibit # 8, Dietary tray audit)

Resident #17, a systemic evaluation was performed by the IDT. The process was modified to have the unit Coordinator to validate new Physician orders with MAR on a daily basis. (See Exhibit # 9, Inservice on order review process).

4. RSD # 17, Medical Records Director will perform an audit on new Physician orders weekly to ensure correct transcription and implementation of Physician orders as related to Medication Administration Record. (See Exhibit # 10, MR audit)

RSD #3, #10, An audit will be completed daily for one month then weekly for one month, then monthly thereafter by Dietary Manager or Assistant Dietary Manager to ensure accuracy of ordered diets. (See Exhibit # 8, dietary audit). Results of audits will be presented and reviewed before the Quality Assurance Committee on a monthly basis.

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F 281	<p>Continued From page 5 intake.</p> <p>Review of resident #3's physician orders dated August 1, 2010, revealed a diet of high calorie, high protein, mechanical soft, and ground meats with ice cream was ordered for lunch and dinner. Additional record review of Nutrition/Nursing Communication revealed resident #3's order for ice cream at lunch and dinner was communicated to the dietary staff.</p> <p>Observation on August 17, 2010, at 6:05 p.m., revealed resident #3 was fed by a Certified Nurse Assistant (CNA). Observation of resident #3's dinner meal tray revealed no ice cream on the meal tray. Additional observation on August 18 2010, at 12:15 p.m., revealed resident #3's lunch meal tray contained no ice cream.</p> <p>An interview conducted on August 19, 2010, at 9:00 a.m., with the Registered Dietitian revealed a recommendation was made for resident #3 to receive ice cream with the lunch and dinner meal to increase the resident's calorie intake.</p> <p>An interview conducted on August 18, 2010, at 3:00 p.m., with CNA #1 revealed he/she assisted resident #3 with dinner on August 17, 2010, and lunch on August 18, 2010. CNA #1 did not recall any ice cream being available on resident #3's dinner or lunch tray. CNA #1 stated he/she was not aware the resident was to have ice cream for lunch and dinner.</p> <p>An additional interview conducted on August 18, 2010, at 3:15 p.m., with the Licensed Practical Nurse (LPN) revealed the LPN did not observe ice cream on resident #3's dinner tray on August 18, 2010. The LPN stated resident #3 should</p>	F 281			

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F 281	<p>Continued From page 6</p> <p>have received ice cream on the lunch tray</p> <p>3. Resident #10 was admitted to the facility on January 21, 2010, with medical diagnoses to include Protein-Calorie Malnutrition, Hypopotassemia, Iron Deficiency Anemia, and Anxiety.</p> <p>A review of resident #10's medical record revealed on July 28, 2010, the resident's physician had ordered ice cream for lunch and dinner. A review of the Registered Dietitian's progress note dated July 28, 2010, revealed resident #10 experienced a weight loss of 5.8 percent over the past six months and made a recommendation to give the resident ice cream at lunch and dinner due to weight loss.</p> <p>A review of a care plan updated on July 29, 2010, revealed the facility identified weight loss as a problem for resident #10. The care plan goal was for the resident to sustain no further weight loss. According to the care plan, ice cream was required to be offered to resident #10 only after the resident refused to drink a dietary supplement.</p> <p>Observation conducted on August 17, 2010, at 5:45 p.m., revealed ice cream was not served on resident #10's dinner meal tray. Additional observation conducted on August 18, 2010, at 12:00 p.m., revealed no ice cream was served on the resident's lunch meal tray.</p> <p>An interview conducted on August 17, 2010, at 6:05 p.m., with resident #10 revealed she did not receive ice cream with the dinner meal but stated sometimes the staff would bring it later. Additional interview conducted on August 18,</p>	F 281	

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NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40039	
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F 281	Continued From page 7 2010, at 9:00 a.m., revealed the resident was unsure if he/she received ice cream for dinner the previous night. Resident #10 stated he/she did like ice cream and ate it to help her gain some weight. An interview conducted on August 18, 2010, at 3:00 p.m., with CNA #2 revealed the CNA was unaware resident #10 was to have ice cream for lunch. Additional interview conducted on August 18, 2010, at 3:25 p.m., with the Dietary Manager revealed resident #10 should have received ice cream for lunch and dinner and it should have been sent out on the meal tray.	F 281		
F 323 SS=D	483.25(n) 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 observations and interviews, it was determined the facility failed to maintain a hazard free environment for residents. Observations on August 17, 2010 of the house-keeping cart revealed cleaning chemicals stored on top of the cart, and the door to the cart could not be locked to prevent access by residents. Observations on August 18, 2010, revealed housekeeping staff using a cart that had no means to enclose the	F 323	F-323 1- The open cart was immediately taken out of service as a cleaning cart. The substances were immediately removed from the top of the cart and stored in the closed locked cart. The Administrator replaced the faulty lock with a tested and fully functioning lock. The Housekeeping staff involved were counseled and received re-training at that time (See Exhibit # 11, counseling form). 2. Due to the nature of the deficient practice all residents were deemed at risk due to this practice. 3. All housekeeping staff were re-educated on Cedars of Lebanon safety and accident policy to determine areas of education that were lacking that may be attributed to preventing an accident free culture at Cedars. (See Exhibit # 12, inservices agenda).	

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F 323	Continued From page 8 cleaning chemicals in use. The findings include: 1. Observations on August 17, 2010, at 10:50 a.m., revealed a housekeeping cart between the facility's front entrance and room 134 on the Davis Hall. The cart had a spray bottle of Scrub Free cleanser on the bottom exterior shelf of the cart and a small open bucket of liquid on the top shelf of the cart. The door to the interior of the cart was unlocked and the interior shelf contained Virax chemical disinfectant, Oxy multi-purpose cleaner, furniture polish, and Windex window cleaner. Each of the cleaning chemicals contained a warning that the cleaner was harmful if swallowed. The bottle of Scrub Free had a manufacturer's warning that contact with the eyes and skin could cause irritation and that the chemical was harmful if swallowed. Interview on August 17, 2010, at 10:55 a.m., with the housekeeper using the cart on the Davis Hall revealed staff was required to keep the cleaning cart locked. According to the housekeeper, the lock for that cart did not work and the cart could not be locked. 2. Observations on August 18, 2010, at 9:45 a.m., revealed housekeeping staff using a cart on the Raley Hall. The cart had no enclosures and cleaning chemicals were observed in an open bucket on top of the cart. The bucket contained Virax disinfectant and lemon furniture polish. The second shelf of the cart contained two containers of antibacterial soap and paper products. Interview on August 18, 2010, at 9:45 a.m., with the housekeeper using the open cart revealed the	F 323	F - 323 Continued 4. The Housekeeping Supervisor, DON ADON, or Administrator will perform a daily safety monitor seven days a week on all shifts that housekeeping staff are scheduled for one month or until 100% compliance x 30 days has been achieved. This will include monitoring for cleanliness of cart, chemicals left in open areas and lock functionality. Then randomly (One cart on each shift to include all four carts) x 30 days and will report and submit findings to the for Quality Assurance Committee for input and oversight. (See Exhibit # 13, Quality monitor for carts).	09/10/10	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 9 facility had three carts that were enclosed. According to the housekeeper, when those carts were in use staff was required to use the cart that was open.	F 323			
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 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.	F 431	F-431 1. The vaccine was immediately taken out of use and disposed through contracted pharmacy services. The LPN that failed to follow facility policy was counseled and re-educated to the need to follow policy. (See Exhibit # 14, Counseling form) 2. Vaccination records were reviewed by the Interdisciplinary Team to determine if any residents had received the vaccination. One resident had received the vaccine. The IDT consulted with the resident physician and the pharmacist reaching a determination that there would be no adverse reactions and that the test should not be re-administered due to records indicating in question was within the time period for use and had not lost potency. 3. A monitor for the dating of opened drugs was enacted. The Unit Coordinator will be required to check each vial daily and discard any unusable drugs and alert the Director of Nursing. 4. The Director of Nursing will perform quality monitor for oversight every two weeks for one month or until compliance of 100% x 30 has been achieved. Then monthly and report findings and corrections to the Administrator and the Quality Assurance Committee. (See Exhibit # 15, Quality Monitor)		09/10/10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ E. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033	
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F 431	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and manufacturer's directions for use, it was determined the facility failed to label all drugs and biologicals in accordance with currently accepted professional principles. The facility failed to label one (1) vial of Tuberculin Purified Protein Derivative (PPD) with an expiration date. The findings include: Observations on August 18, 2010, at 3:20 p.m., of the medication refrigerator on the Davis Hall revealed a vial of PPD that had been opened. The vial had a label that was to document the date the vial had been opened. The vial had no date to indicate when the vial had been opened and no expiration date could be determined. Review of the manufacturer's medication insert revealed "A vial of Tuberculin PPD which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency." Interview with the Director of Nursing (DON) on August 18, 2010, at 3:30 p.m., revealed staff was required to date all multiple-dose vials of medication with the date the vial was opened to determine the expiration date. The DON stated the PPD would expire 30 days after opening for use.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		
The facility must establish and maintain an				

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NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033	
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F-441	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F-441	F-441 1. The LPN was counseled and re-educated on the facilities policy and procedure of disinfecting the glucometer before and after use of the machine to prevent the potential spread of bacteria.(See Exhibit #16, Counseling form). The glucometer was removed from services and cleaned per manufactures guidelines. The clean cart was removed from contact with the trash container and the area of contact was cleaned. The dinning room monitor was counseled and re-educated on the deficient practice.(See Exhibit #17, Counseling form) 2. The IDT evaluated and determined that those residents that received meals in the dining room and residents that received glucose monitoring had the potential to be affected. 3. Inservice staff on glucometer cleaning policy relating to the cleaning of the glucometer.(See Exhibit # 18, Glucose testing procedure inservice agenda, sign in sheet,). All licensed staff were educated by inservice on 09/03/10 and were not permitted to utilize the machine until checked off by Staff Development Registered Nurse, Director of Nursing or Assistant Director of Nursing. The area around the disposal units was blocked off and clearly marked so that clean containers could not be placed in proximity of the disposal units.(See Exhibit # 19, work order for barreir around trash can)	

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No. 2401 3. 7

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
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F 441	Continued From page 12 manufacturer's directions for use, it was determined the facility failed to ensure infection control procedures were in place for disinfection of the glucometer used for multiple patient glucose monitoring. Staff was observed to use the glucometer for glucose testing without disinfecting the meter prior to and after use as required for one (1) unsampled resident (resident #18). The facility failed to ensure clean coffee cups, coffee, water, and condiments were protected from possible contamination. Observations in the Dining Room revealed a dietary cart containing clean coffee cups, coffee, wafer, and condiments was in direct contact with an open, full trash can. The findings include: 1. Review of the facility policy/procedure 'Blood Glucose Monitoring and Sliding Scale Insulin' with an effective date of October 1, 2007, and a revised date of September 23, 2008, revealed staff was required to clean the glucose monitor before and after each use. Review of the manufacturer's directions for use revealed the glucometer was required to be disinfected between every use using an Environmental Protection Agency (EPA) registered product which was effective against bloodborne pathogens. Observations on August 17, 2010, at 3:52 p.m., revealed the Licensed Practical Nurse (LPN), responsible for medication administration prepared to check the glucose level of resident #18. The LPN removed the glucometer from the drawer of the medication cart, donned gloves, and proceeded to resident #18's room. The LPN	F 441	F - 441 Continued. 4. The unit supervisor, DON or ADON will monitor glucose monitoring techniques for infection control deficiencies daily for a period of one week then weekly for a period of one month until 100% compliance has been achieved x 30 days. (See Exhibit # 20, Glucose monitoring QA monitor). The dining room co-ordinator or Charge Nurse will monitor and check off that clean carts are not in proximity of disposal units daily for a period of one week or until 100% compliance x 7 days has been achieved. The Director of Nursing or ADON will monitor weekly for two weeks until 100% compliance has been achieved x 14 days monitor and sign that clean carts are not in proximity with disposal units.(See Exhibit # 21, Disposal container monitor)	09/10/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(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 13 placed the glucometer onto the resident's chest, used a lancet to obtain a blood sample, and checked the resident's glucose. The LPN discarded the lancet and glucometer strip, removed the gloves, washed the hands, and picked up the glucometer. The LPN placed the glucometer back in the top drawer of the medication cart. The LPN did not disinfect the glucometer prior to using or after use for resident #16. Interview with the LPN on August 17, 2010, at 3:58 p.m., revealed the LPN was not responsible for disinfecting the glucometer. According to the LPN, the night shift nursing staff was responsible for disinfecting the glucometer one time a week. The LPN stated the glucometer was not disinfecting between resident uses. Interview on August 18, 2010, at 12:50 p.m., with the Charge Nurse on the Raley Hall revealed staff was required to clean the glucometer before and after each resident use. Interview on August 18, 2010, at 1:05 p.m., with the Director of Nursing (DON) revealed staff was required to disinfect the glucometer before and after each resident use in accordance with the manufacturer's directions. 2. Observation in the dining room during the noon meal at 12:00 p.m. on August 17, 2010, revealed a clean cart containing coffee, water, clean coffee cups, individual mayonnaise and catsup packets, salt/pepper packets, sugar/sugar substitute packets, and individual coffee creamer packets was sitting in direct contact (touching) with an open, full trash container. An interview conducted at 12:05 p.m. on August 17, 2010, with	F 441			

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F 441	Continued From page 14 a staff member working in the dining room revealed the clean cart was not supposed to be touching the garbage can. The staff member stated that the cart must have been misplaced because the clean cart was supposed to sit away from the garbage can.	F 441			
F 455 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The floors in resident rooms were observed to have a black substance around the perimeter of the floors. The floor in the hallway of the Raey Hall had dirt, debris, and a black substance adjacent to the baseboard under the heat register. The shower room on the Davis Hall had broken/missing tile and the shower had a black substance around the bottom layer of tile. A pipe in the hallway outside room 101 was dripping water onto the floor. Housekeeping carts were observed to have dirt/debris on the surface and one cart was observed to have black/grey mop water. A section of baseboard was missing in the Davis Hall men's restroom. The findings include: 1. Observations on August 17, 2010, during a	F 455	F - 465 1. Each room was immediately cleaned of any dirt and / or debris by the use of scrub pads cleansing agents. Housekeeping Supervisor was counseled (See Exhibit # 22, counseling form HK Supervisor) related to the overall unacceptable cleanliness of the facility. The floor and the hallway was immediately cleaned. The black substance was removed by scrubbing and replacing tiles at the baseboard area. (Exhibit # 23, Baseboard work order) A work order was developed for the missing tile in the shower room on Davis Hall, the tile was replaced and regouted. (See Exhibit # 24, Tile work order) The shower room was immediately cleaned of any dirt and debris utilizing a scouring pad and cleansing agents. The cleaning cart was immediately cleaned, the cleaning bucket was emptied and disinfected. The undesirable water was replaced with fresh cleaning solution. The water on the floor outside room 101 was cleaned up immediately. A wet floor sign was placed outside room 101 to warn guests and residents of the potential hazards. The baseboard located in Davis Hall bathroom was replaced immediately by maintenance personnel		

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(X4) D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 465	<p>Continued From page 15</p> <p>four of the facility revealed each room on the Davis Hall had a black substance around the perimeter of the floor. Dust and debris were observed in the corners of each room. Observation of the hallway on the Raley Hall between rooms 112 and 114 revealed a black substance with dirt/debris on the edge of the floor underneath the heating return register. The floors in each room on the Raley Hall were observed to have a black substance around the perimeter of the floor.</p> <p>Interview on August 17, 2010, at 12:20 p.m., with the Housekeeping Supervisor revealed the supervisor made daily checks of the resident rooms. The supervisor stated she was aware of some of the problems with the floors in the rooms but was unaware the problem was in all the rooms.</p> <p>2. Observation of the shower room on the Davis Hall on August 17, 2010, at 12:40 p.m., revealed a black substance around the back and two sides of the shower at the floor level extending up the first line of tile. The lower right corner of the shower room near the door approximately three inches high by two inches wide had an area missing tile. The area had a sharp edge protruding out.</p> <p>Interview on August 18, 2010, at 2:45 p.m., with the Maintenance Supervisor revealed the Maintenance Supervisor was unaware of the broken tile. The Maintenance Supervisor stated the broken tile had not been reported to him.</p> <p>3. Observations on August 18, 2010, at 10:15 a.m., revealed a housekeeping cart on the Davis Hall. The cart had dirt and debris on the exterior</p>	F 465	<p>F - 465 Continued.</p> <p>2. Due to the nature of the deficient practice it was determined that all residents had the potential to have been affected by practice.</p> <p>3. Housekeeping policy was enacted in addition to the infection control policy which mandates the daily disinfecting and cleaning of all the housekeeping carts. Housekeeping staff were given quality check sheets that are to be completed as they perform daily maintenance and cleaning on their carts. (See Exhibit # 25, Staff quality check sheets) Safety rounds are completed each month. Included to these rounds were monitors for the air conditioning condensate tubes general cleanliness of facility.</p> <p>4. Housekeeping Director will complete daily monitor for cleanliness of facility staff equipment for one month then will continue the monitor on a weekly basis for one month then monthly until 100% compliance is achieved. See Exhibit # 26, Housekeeping audit) The monitors will be reported and discussed with input from the Quality Assurance Committee.</p>
			09/10/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY, 40033	
(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 465	Continued From page 16 bucket ledge. The water in the mop bucket was black/grey in color and was being used to clean the floors in resident rooms. Interview on August 18, 2010, at 10:15 a.m., with the housekeeping staff responsible for the cart on the Davis Hall revealed the facility had no set schedule for cleaning the housekeeping carts. The staff member could not remember when the cart had last been cleaned. Interview with the Housekeeping Supervisor on August 18, 2010, at 1:30 a.m., revealed staff was required to change the mop water after every fourth room or as needed. The supervisor stated the water in the cart should have been changed and it was too dirty to use. 4. Observations on August 18, 2010, at 2:00 p.m., revealed the area outside room 101 on the Raley Hall had water on the floor. There were no signs to alert staff, visitors, or residents to the wet floor. Observation above the floor revealed a pipe going across the soffit above the hallway. The pipe was observed to have water dripping onto the floor from a small crack near the pipe joint. Interview on August 18, 2010, at 2:30 p.m., with the Maintenance Supervisor revealed the supervisor was unaware the pipe was leaking. According to the supervisor, the increased humidity outside had caused condensation that was dripping onto the floor. The supervisor stated the pipe would do that a few times a year. 5. Observations of the men's restroom on the Davis Hall on August 18, 2010, at 10:30 a.m., revealed a three-inch by three-inch area of	F 465		

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F 465	Continued From page 17 baseboard missing to the left of the sink leaving exposed drywall. Interview with the Housekeeping Supervisor on August 18, 2010, at 10:30 a.m. revealed the supervisor was unaware the baseboard was missing and had not reported it to the Maintenance Department.	F 465			
F 504 SS=D	483.75()(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide or obtain laboratory services when ordered by the attending physician for one (1) of seventeen (17) sampled residents (resident #3). The facility staff failed to obtain laboratory tests for Methylmalonic Acid Level ordered for June 2010. The findings include: Resident #3 was admitted to the facility on December 31, 2009, with medical diagnoses to include Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anemia, and Depression. The record review revealed a telephone physician's order dated June 16, 2010, to obtain labs for a Methylmalonic Acid Level in June 2010 for resident #3. Additional review of resident #3's record revealed no lab result for a Methylmalonic	F 504	F - 504 1. Resident #3 Physician was contacted and alerted to the missed lab. He advised to obtain the lab next day and that there were no adverse reaction to the missing as the lab was to be obtained yearly. 2. A chart review was conducted per medical records to review all charts for possible errors related to the deficient practice, any discoveries were corrected immediately. 3. A system review was conducted by the Director of Nursing in conjunction with the IDT, which reveal areas for system improvements. The flow of information such as Physician lab orders will be conducted as follows: The Nurse receives the order and order is transcribed on a triplicate order form (See Exhibit # 27, Lab requisition form) the original accompanies resident/specimen to laboratory after being logged in lab book, second copy is given to Director of Nursing and logged into yearly calendar, third copy is received by medical records personnel where it is checked against the actual order and the Lab requisition calendar a third time.		

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F 504	Continued From page 18 Acid Level was performed in June 2010. An interview conducted on August 18, 2010, at 5:50 p.m., with the Director of Nursing (DON) revealed after the DON reviewed the chart she/he was unable to find the lab result for resident #3. The DON further revealed the physician was notified on August 18, 2010, of the Methylmalonic Acid Level not obtained in June 2010 as ordered. The DON further stated a new order was obtained for the lab to be drawn on August 18, 2010.	F 504	F - 504 Continued 4. The Nurse receives the order and order is transcribed on a triplicate order form (See Exhibit # 28, Quality Monitor for MR and nursing) the original accompanies resident specimen to laboratory after being logged in lab book, second copy is given to Director of Nursing and logged into yearly calendar, third copy is received by medical records personnel where it is checked against the actual order and the Lab requisition calendar a third time. Following the afore mentioned plan the Director of Medical Records will conduct a daily monitor for one month until 100% compliance is achieved x 30 days to ensure labs are completed as ordered. This monitor will then be reported to Director of Nursing. The Director of Nursing, ADON or Administrator will audit lab orders for their completeness and independantly from Medical Records Director on a random basis. Any suspected discrepancies will be remedied immediately. The medical records quality monitor and Nursing monitor will be reviewed, reported and discussed with the Quality Assurance Committee for recommendations if needed.	09/10/10	

Exhibit 1

Performance Improvement Form

(Press TAB or your mouse to maneuver between fields or lines. Do not press "Enter")

Employee name:	Today's date: 8/17/10
Department/facility:	Date of hire:
Position: LPN	Supervisor:

REASON FOR COUNSELING/CORRECTIVE ACTION:

Failure to pull curtains completely closed during
 medical treatment therefore failing to provide dignity
 & privacy to RSD

HAS THIS CONCERN BEEN PREVIOUSLY DISCUSSED WITH THE EMPLOYEE? LIST ANY PREVIOUS COUNSELING SESSIONS/CORRECTIVE ACTIONS:

NO

EXPECTED LEVEL OF PERFORMANCE:

improvement

COUNSELING/ CORRECTIVE ACTION (Please mark with 'X')	<input checked="" type="checkbox"/> Verbal counseling	<input type="checkbox"/> Extension of orientation period
	<input type="checkbox"/> Written warning	<input type="checkbox"/> Demotion
	<input type="checkbox"/> Final written warning	<input type="checkbox"/> Suspension
	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other

Exhibit 2

**Cedars of Lebanon / Village of Leb
In-Service Lesson Plan**

In-Service Subject: Treating Residents with Dignity - Patient Rights / Resident Abuse

Dates: September 3, 2010

Presenter: Jennifer Bartley, RN, BSN, DON / Tamara D. Gribbins, RN, BSN, MOI,
Staff Development Coordinator

Target Audience: This in-service is intended for licensed and non-licensed health personnel including, Nursing Services, (RN's, LPN's, SRNA's, CMA's, CMT's) Environmental Services, Nutritional Services, Social Services, Activity Services, Maintenance Services, and Administrative personnel.

Learning Objectives:

1. Define the different types of elder abuse and neglect
2. Detail the rights of residents / patients
3. Incorporate rights and dignity into all aspects of care
4. Potential causes and warning signs of abuse
5. Reporting requirements / Cedars of Lebanon Abuse Policy & Procedure review
6. Legal aspects of abuse and neglect

Methods of Instruction:

1. Maintaining Selfhood and Dignity in Patients with Alzheimer's Disease Theory; www.econline.net; Lippincott Manual of Nursing Practice; The Nursing Assistant: Acute, Subacute and Long Term Care theory
2. Text & Workbook
3. Presentation with follow-up review of Cedars of Lebanon Abuse Policy & Procedure
4. Discussion

Methods of Evaluation:

1. Question & Answer Sessions
2. Review questions
3. Pre-test / Post-Test Assessment

Time to Complete In-Service:

Minimum of 60 minutes or one hour

Credits Available:

State Registered Nurse Assistants: minimum of one credit hour pertaining to minimum of 12 hours of ongoing annual staff development requirement per Cabinet for Health and Family Services Department for Medicaid Services Nurse Aide Training and Competency Evaluation Program.

All other healthcare professionals completing continuing education credit for this activity will be issued a certificate of participation as requested



Village of Lebanon d.b.a. Cedars of Lebanon

Sign-In Sheet

Mindy Brown	Kim Wayne
Mindy Bohannon	Phyllis Skays
Vicky Proath	David Edwards 10/10
Bonnie Patton	Shirley Osborne
Lizette Haver	Lisa Sullivan
Nancy Mattingly	Avery Rogen
Betty Ford	Janet Dunt
Donald Chen	Jenny Bond
Arley Allen	J. Kigg
Leah Johnson	Charlotta in
Judy Miller	Alexis Smith
Michelle Chess	Susan Potts
Ashley Carr	Robert Andrews
Cheryl Hare	Christel off
James Loney	Cathy Evans
Statia Brady	
Courtney Chesel	
Karney Raikes	

Exhibit 3

Exhibit 4

Dignity

Facility Name: _____ Date: _____

Indicator	Yes	No	Comments
1. Are privacy or window curtains pulled during provision of care?			
2. Does the staff knock on doors and wait for a response prior to entering?			
3. Is full visual privacy provided during bathing/showering?			
4. Are treatments and medications provided or administered in a private area (not in hallway, dining room, etc.)?			
5. Is resident facial hair (male or female) removed?			
6. Are residents' nails cleaned and trimmed?			
7. Are residents dressed in appropriate clothing?			
8. Do residents have appropriate footwear (shoes/socks)?			
If socks only: Does care plan reflect this need or choice?			
9. Is there evidence that proper mouth care has been provided to residents?			
10. Does the staff treat residents with respect, including addressing them by preferred names (not endearments or pet names)?			

Dignity Audit

2

<i>Indicator</i>	<i>Yes</i>	<i>No</i>	<i>Comments</i>
11. Are catheter bags covered when residents are up in a chair?			
12. Are clothing protectors worn only during meals and with resident permission?			
13. Is clothing labeled properly (not visible on outside of clothing)?			
14. Is confidential resident information (chart, notes, assignment sheets) kept out of public view?			

Exhibit 5

Performance Improvement Form

(Press TAB or your mouse to maneuver between fields or lines. Do not press "Enter")

Employee name:	Today's date:
Department/facility <i>Activities</i>	Date of hire:
Position <i>Activities Director</i>	Supervisor:

REASON FOR COUNSELING/CORRECTIVE ACTION:

- Failure to provide and/or oversee activities program leading to lack of activities for residents.

HAS THIS CONCERN BEEN PREVIOUSLY DISCUSSED WITH THE EMPLOYEE? LIST ANY PREVIOUS COUNSELING

SESSIONS/CORRECTIVE ACTIONS:

Through out year discussed with AD the need for varied activities throughout the week.

EXPECTED LEVEL OF PERFORMANCE:

Immediate improvement

COUNSELING/ CORRECTIVE ACTION

(Please mark with "X")

- Verbal counseling
- Written warning
- Final written warning
- Discharge
- Extension of orientation period
- Demotion
- Suspension
- Other

Exhibit 7

Employee Name: -	Today's Date: 8/17/10
Department/facility: /	Date of Hire:
Position: LPN	Supervisor:
Reason for Counseling/Corrective Action:	
Employee gave Prevalite At wrong time. It was given before meals, it was to be give AFTER meals. It was transcribe incorrectly.	
Has this Concern Been Previously Discussed with the Employee? List any previous counseling sessions/corrective action:	
no.	
Expected Level of Performance:	
improvement immediately.	
Counseling/Corrective Action: (Please mark with X)	<input checked="" type="radio"/> Verbal counseling <input type="radio"/> Written warning <input type="radio"/> Final written warning <input type="radio"/> Discharged <input type="radio"/> Extension of orientation period <input type="radio"/> Demotion <input type="radio"/> Suspension <input type="radio"/> Other

Corrective Action Plan:
Employee counseled & inserviced on medications error
Time Frame for improvement:
immediately
Follow Up Review Date:
Employee informed of open door policy? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no
Employee Statement

Jennifer Battley Robinson

Exhibit 9

**Cedars of Lebanon / Village of Lebanon
In-Service Lesson Plan**

In-Service Subject: Physician Order Validation Process
Information In-service

Date(s): September 03, 2010

Presenter: Jennifer Bartley, RN, BSN, Director of Nursing
Tamara D. Gribbins, RN, BSN, MOI, CRN-C
Staff Development Coordinator

Target Audience: This in-service is intended for licensed health personnel in Nursing Services.

Objective:

1. Prevention of Physician Order Errors, including but not limited to, Medications / Treatments / Nutritional Services / Rehabilitative / Laboratory / etc.
2. Validation of physician orders will be maintained.

Procedure:

1. Unit Coordinator will validate all new Physician orders with MAR / treatment sheets on a daily basis.
2. Medical Records Director will perform weekly audit on all new Physician orders to ensure correct transcription and implementation of Physician orders as related to Medication Administration Record / treatments / etc.

Methods of Instruction:

1. Presentation with follow-up review of Cedars of Lebanon medication error process
2. Discussion
3. Question / Answer Session



Village of Lebanon d.b.a. Cedars of Lebanon

Sign-In Sheet	
September 3, 2010	
Vicky Proalke	
Connie Roshon LP	
Leeie Starned LP	
Janey Mattingly	
Betty Foster	
Mindy Bohannon LP	
Amy Brown LP	
Shirley Osborne LP	
Phyllis Skaggs	
Lona Sullivan	
Suzanne	
Robt Simpson RN	
Natalie Wheaton LPN	
Arnold Coffey RN	
Cindy Evans	

Exhibit 11

Performance Improvement Form

(Press TAB or your mouse to maneuver between fields or lines. Do not press "Enter")

Employee name:	Today's date: 8/18/10
Department/facility:	Date of hire:
Position: Housekeeping	Supervisor: Kim Brady

REASON FOR COUNSELING/CORRECTIVE ACTION: Chemicals left on top + cleaning cart + hitting residents of the facility in a safety risk.

HAS THIS CONCERN BEEN PREVIOUSLY DISCUSSED WITH THE EMPLOYEE? LIST ANY PREVIOUS COUNSELING SESSIONS/CORRECTIVE ACTIONS: NO Counseling upon hire. Hazards of chemicals is part of their orientation

EXPECTED LEVEL OF PERFORMANCE: To keep all chemicals in locked cart when their not using them

COUNSELING/ CORRECTIVE ACTION (Please mark with "X")	<input checked="" type="checkbox"/> Verbal counseling	<input type="checkbox"/> Extension of orientation period
	<input type="checkbox"/> Written warning	<input type="checkbox"/> Demotion
	<input type="checkbox"/> Final written warning	<input type="checkbox"/> Suspension
	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other

Exhibit 12

**Cedars of Lebanon / Village of Lebanon
In-Service Lesson Plan**

In-Service Subject: Cedars of Lebanon Safety / Accident Policy and Procedures

Date(s): August 19, 2010

Presenter: Kim Brady, Director of Housekeeping Services
Tamara D. Gribbins, RN, BSN, MOI, CRN-C
Staff Development Coordinator

Target Audience: This in-service is intended for licensed and non-licensed health personnel including, Nursing Services, (RN's, LPN's, SRNA's, CMA's, CMT's) Environmental Services, Nutritional Services, Social Services, Activity Services, Maintenance Services, and Administrative personnel.

Objectives:

1. Adherence to basic safety, identification and standard safety precautions on the job.
2. Adherence and reporting requirements / Cedars of Lebanon Safety / Accident Policies & Procedures
3. Identify the factors that contribute to accidents / work related safety hazards
4. Identify employee's role in identification safety hazards and prevention of accidents
5. Proper handling and appropriate storage of chemicals, including cleaning supplies / Medications / disinfectants, etc.
6. Review of OSHA standards / Location of Disaster plans / MSDS information sheets / etc.

Methods of Instruction / Evaluation:

1. Presentation with follow-up review of Cedars of Lebanon Safety / Accident Policy
2. Discussion as listed above
3. Open Question / Answer Session
4. Quality Improvement studies / Unannounced Audits of Cleaning Carts / Supply Closets / Medicine Rooms / Chemical storage areas



Village of Lebanon d.b.a. Cedars of Lebanon

Sign-In	
August 19, 2010	
Maranda M. Harris	maranda.m. Harris
Becky Lewis LPN	B Lewis LPN
Amy Brownington	Amy Brownington
Harvey Rogers SRNA	Harvey Rogers SRNA
Judy Gruber	Judy Gruber CNA
Natasha Brady	Natasha Brady
Renee Filiatreau	Renee Filiatreau
Letty Ford CMA	
Farran Mattingly	Farran Mattingly
TERRY MATTINGLY	Terry Mattingly
Kim Wayne	Kim Wayne
Kim Brady	Kim Brady
MAR Jorie Whalen	MAR Jorie Whalen
DIANA McQuary	Diana McQuary
Tammy Gibbins	Tammy Gibbins, RN
Joni Hall	Joni Hall
Cassie Rafferty	Cassie Rafferty RN
Sherry Mattingly	Sherry Mattingly

VILLAGE OF LEBANON
INSERVICE ATTENDANCE ROSTER

Name (Print below)	Signature (Sign below)
Susan Mattingly	Susan Mattingly
Courtney Carter	Courtney Carter
Chad Kib	Chad Kib
Teresa Hall	Teresa Hall
Aaron Howard	Aaron Howard
Melissa Leedom	Melissa Leedom
Olivia Mattingly	Olivia Mattingly
Ann Taylor Smith	Ann Taylor Smith
Vicky Prother	Vicky Prother
Jenny Bland	Jenny Bland
Missy Gray	Missy Gray
Deanna Darst	Deanna Darst
Dana Logan	Dana Logan
Heather N. Hall	Heather N. Hall
Jennifer Riggs	Jennifer Riggs
Savannah Byrd	Savannah Byrd
Susan Leedom	Susan Leedom
Amanda Washington	Amanda Washington
Darlene Walston	Darlene Walston
Jennifer Hurst	Jennifer Hurst
Brittany Blanford	Brittany Blanford
Julie Mattingly	Julie Mattingly
Felicia Blair	Felicia Blair
Michelle Edwards	Michelle Edwards

Received Time Sep. 10, 2010 9:57PM No. 2675

Michael Prother

Exhibit 14

Employee Name:	Today's Date: 8/18/10
Department/facility: J	Date of Hire:
Position:	Supervisor:
Reason for Counseling/Corrective Action:	
Employee failed to date a multidose vial AFTER opening	
Has this Concern Been Previously Discussed with the Employee? List any previous counseling sessions/corrective action:	
no	
Expected Level of Performance:	
Employee will date All multidose vials AFTER opening	
Counseling/Corrective Action (Please mark with "X")	<input checked="" type="radio"/> Verbal counseling <input type="radio"/> Written warning <input type="radio"/> Final written warning <input type="radio"/> Discharged <input type="radio"/> Extension of orientation period <input type="radio"/> Demotion <input type="radio"/> Suspension <input type="radio"/> Other

Corrective Action Plan:
<i>Employee will neutralize understanding of the need to complete date multi dose vial</i>
Time Frame for Improvement:
<i>immediately</i>
Follow Up Review Date:
Employee informed of open door policy? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no
Employee Statement

Jennifer Battaglia

Exhibit 16

Employee Name:	Today's Date: 8/17/10
Department/facility:	Date of Hire:
Position:	Supervisor:
Reason for Counseling/Corrective Action:	
Failure to clean glucometer in before and after each use in between RSD's.	
Has this Concern Been Previously Discussed with the Employee? List any previous counseling sessions/corrective action:	
no	
Expected Level of Performance:	
improvement	
Counseling/Corrective Action: (Please mark with "X")	<input checked="" type="radio"/> Verbal counseling <input type="radio"/> Written warning <input type="radio"/> Final written warning <input type="radio"/> Discharged <input type="radio"/> Extension of orientation period <input type="radio"/> Demotion <input type="radio"/> Suspension <input type="radio"/> Other

Corrective Action/Plan:

Employee will verbalize understanding of the need to clean glucometer between each RSD.

Time Frame for Improvement:

immediately

Follow Up Review Date:

Employee informed of open door policy? yes no

Employee Statement

Janis Castley

Exhibit 17

Employee Name:	Today's Date: <i>8/17/10</i>
Department/facility:	Date of Hire:
Position:	Supervisor:
Reason for Counseling/Corrective Action:	
<i>infection control non compliance in monitoring the dining room. trash can in contact with clean cart</i>	
Has this Concern Been Previously Discussed with the Employee? List any previous counseling sessions/corrective action:	
<i>NO</i>	
Expected Level of Performance:	
<i>improvement</i>	
Counseling/Corrective Action: (Please mark with "X")	<ul style="list-style-type: none"> <input checked="" type="radio"/> Verbal counseling <input type="radio"/> Written warning <input type="radio"/> Final written warning <input type="radio"/> Discharged <input type="radio"/> Extension of orientation period <input type="radio"/> Demotion <input type="radio"/> Suspension <input type="radio"/> Other

Corrective Action Plan:
<i>The trash can will not be in contact with the clean dining room cart</i>
Time Frame for Improvement:
<i>immediate</i>
Follow Up Review Date:
Employee informed of open door policy? yes no
Employee Statement

Jennifer Batty

Exhibit 18

MEMORANDUM

TO: RN'S / LPN'S / CMA'S
FROM: TAMMY GRIBBINS, RN, SDC / JENNIFER BARTLEY, RN, DON
DATE: 09/2/2010
RE: MANDATORY INSERVICE - COMPETENCY
GLUCOMETER TESTING PROCEDURE

MANDATORY IN-SERVICE RN'S / LPN'S / CMA'S GLUCOMETER TESTING PROCEDURE

WHEN: FRIDAY, SEPTEMBER 3, 2010

WHERE: DINING ROOM / INDIVIDUAL NURSING WINGS

TIME: 10:00 AM AND 2:00 PM (SKILLS CHECK OFF - 10-15 MINUTES MAXIMUM)

PRESENTER: TAMARA D. GRIBBINS, RN, BSN / JENNIFER BARTLEY, RN, DON

PURPOSE: GLUCOMETER TESTING PROCEDURE - COMPETENCY

IF YOU ARE UNABLE TO COMPLETE THE SKILL YOU WILL NOT BE ALLOWED TO WORK.
PLEASE CONTACT TAMMY OR JENNIFER TO ARRANGE A TIME FOR THE SKILL
COMPETENCY ASSESSMENT IF YOU ARE UNABLE TO ATTEND AT THE ABOVE POSTED
TIMES.

ALL LICENSED NURSES AND CMA'S / CMT'S
MUST COMPLETE THE SKILL CHECK OFF.

THANKS!

QUINTET™ BLOOD GLUCOSE TEST STRIP INSERT

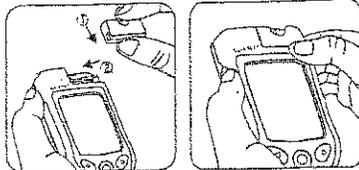
Intended Use

Your QUINTET™ meter is designed to be used as a system and must be used with QUINTET™ glucose test strips. Even if other strips appear to be similar, you must use QUINTET™ strips in order to achieve a proper and accurate reading.

- QUINTET™ Test Strips are intended for testing outside the body (*in vitro* diagnostic use) only.
- The QUINTET™ System tests the capillary whole blood (CB) and provides results equivalent to a laboratory instrument (Plasma equivalent). Samples for testing are extracted from the fingertip, palm or forearm.
- The QUINTET™ Blood Glucose Test Strip is designed for use with the QUINTET™ Blood Glucose Meter (BGM).
- The QUINTET™ Blood Glucose Monitoring System includes meter, Dummy Code Key and Control Solutions.

Test Procedure

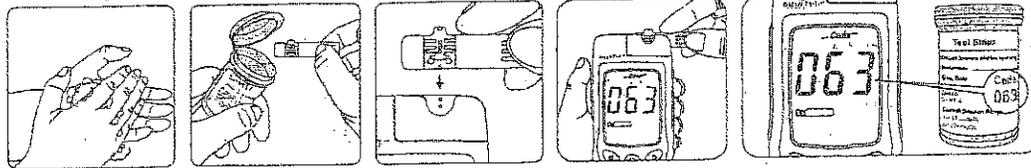
REFER TO THE QUINTET™ USER'S MANUAL FOR MORE DETAILED INFORMATION.



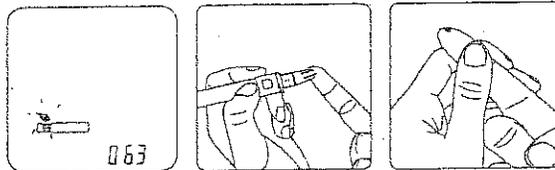
Smart Code Key Installation

1. With the Meter off, follow steps ① and ② to put the new Smart Code Key into the track on code key base.
2. Push down the Smart Code Key until it snaps into the Smart Code Key base.

Performing a Test

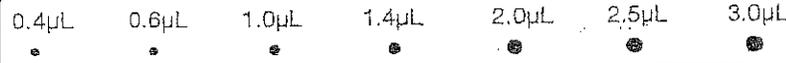


1. Make sure hands are clean and dry. Take one strip from the vial. Close the vial cap immediately.
2. Insert the strip into the strip port on meter with the indication symbol facing up. Push the strip in until it snaps and stops. The meter will turn on automatically.
3. Make sure the code number on the meter screen matches the code number on the test strip vial. If code numbers do not match, contact customer service.
4. When a flashing blood drop appears, use an approved lancet to obtain the blood sample.

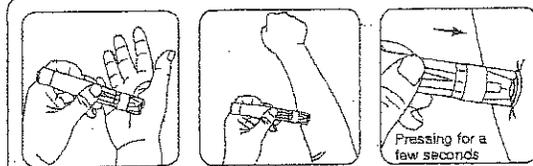


5. Gently squeeze the fingertip to get a drop of blood. The meter only needs a minimum of 0.6µL sample.

Sample Size Example



Take a minimum of 0.6µL sample to perform the test on the glucose monitoring system. Blood sample size above 3.0µL may contaminate the Smart Code Key.

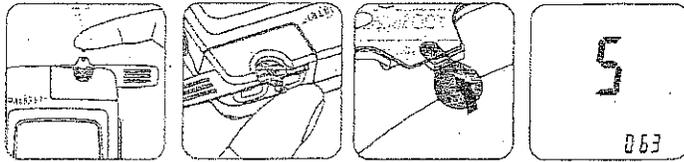


Alternative Site Testing - Palm or Forearm Blood Sampling

- For alternative site testing, use an approved lancing device.
- Massage the puncture area of palm or forearm for a few seconds to increase the blood flow.
- Immediately after massaging the puncture area, press and hold the lancing device against palm or forearm.
- Continue holding the lancing device against the palm or forearm and gradually increase pressure until the blood sample size is sufficient. (Refer to instruction manual for the lancing device).

10% or above 90% relative humidity.

6. Touch and hold the sample drop to the edge of sample entry until a "beep" is heard and the view window is completely filled with blood. If the view window is not completely filled with blood, or the test will not start, discard the test strip and repeat the test with a new test strip.
7. The countdown mode will appear on the screen. After 5 seconds, the test result appears. For more information about test results, see the User's Manual.



For more information on how to use the meter and understand test results, see the User's Manual.

Test Result

- Blood glucose test results are shown on the meter as mg/dL.
- If the blood glucose result is unusually high or low, or if the accuracy of the result is questionable, repeat the test with a new test strip. To ensure that the meter and test strip are working properly, perform quality control tests by using the QUINTET™ Check Key and QUINTET™ Control Solutions. If the test result still remains unusually high or low, contact a physician immediately.
- If symptoms exist that are not consistent with the blood glucose test results and the instructions in this manual have been followed correctly, contact a physician immediately.
- The QUINTET™ Meter displays results between 20 and 600 mg/dL. If the test result is below 20 mg/dL, "Lo" will appear on the screen. Repeat the test with a new test strip. If "Lo" still appears as the result, immediately contact a physician.
- If the test result is above 600 mg/dL, "Hi" will appear on the screen. Repeat the test with a new test strip. If "Hi" still appears as the result, immediately contact a physician.

Expected values for normal glucose level (1)

Status	Range (mg/dL)
Fasting	70-99

Precautions

- Check the expiration date printed on the package every time a test strip is used. Do not use expired test strips.
- Close the vial cap immediately after removing the test strip from the vial.
- Do not perform quality control test with expired control solution.
- Do not bend or twist the test strip. Damage of test strip may cause inaccurate test results.
- Do not reuse test strips.
- Do not reuse lancets. Discard used lancets properly.
- Wait at least 30 minutes to perform a test if the meter has been moved to an area of a different temperature.
- To purchase a new control solution, contact an authorized CONSULT™ representative.

Warning

- Keep the test strips or vial cap away from children. They may be a choking hazard. If a test strip or vial cap is swallowed, contact a physician immediately.

Limitations

- Grossly lipemic (fatty) samples may interfere with some methodologies. To be aware of such interferences, patients under the supervision of a physician should have baseline glucose values established by a clinical laboratory method prior to starting home glucose monitoring. These baseline values should be checked periodically thereafter.
- Meter-read capillary blood glucose values may be significantly lower than "true glucose levels" in the hyperglycemic-hyperosmolar state, with or without ketosis. Critically ill patients should not be tested by the QUINTET™ System, or tested with extreme caution.
- Caution is advised in the interpretation of glucose values below 50 mg/dL or above 250 mg/dL. Consult a physician as soon as possible if values in this range are obtained.
- Healthcare professionals should evaluate their technique and their patients' technique at periodic intervals. To accomplish this, it is recommended that BGM results shall be compared with a concurrently obtained laboratory measurement on the same blood sample. A well characterized clinical laboratory method employing hexokinase or glucose oxidase should be used as the comparative method.
- Fluoride should not be used as a preservative for venous specimens when using blood glucose monitors.
- Hands contaminated with sugar from foods or beverages may cause falsely elevated or inaccurate results.
- Differences in whole blood and serum/plasma values may cause variability in results.
- Storage of test strips near bleach will affect results of glucose oxidase strips.
- QUINTET™ Blood Glucose Test Strips are designed for use with capillary whole blood samples. Do not use serum or plasma samples.
- Incorrect test results may be obtained at high altitude more than 10,000 feet (3,048 meters) above sea level.
- Hematocrits below 30% may cause higher results, and hematocrits above 55% may cause lower results.
- Severe dehydration and excessive water loss may cause inaccurately low results.
- QUINTET™ Blood Glucose Monitoring System has not been validated for use on neonates and therefore, should not be used for neonates.
- Do not perform the blood glucose test at temperatures below 10°C (50°F) or above 40°C (104°F), below 10% or above 90% relative humidity.



Village of Lebanon d.b.a. Cedars of Lebanon

Sign-In Sheet	
Mindy Bohannon, MD	
Bonnie Rosta, MD	
Vicky Prather	
Leanne Swanson	
Nancy Mattingly	
Ree Ford	
Amber Owen, RN	
Phyllis Skayz	
Phyllis Skayz	
Shirley Osborne	
Lina Gubkina	
John Anderson, RN	
Susan Jaffe	
Natalie Whately, LPN	
Christel Goffe	
Andy Egan	

Exhibit 19

INTRAFACILITY REQUEST FOR REPAIRS OR ALTERATIONS

Fac. # COC

INSTRUCTIONS: This form is to be filled out in duplicate by the Supervisor of the department making the request. Both requisitions should then be sent to the Director of Maintenance.

Date 8/19/2010 Location Dining Room Requested by Robbie Eastham

NATURE OF REQUEST (explain fully) Construct a barrier around disposal unit located in Dining Room to prevent accidental contact with any clean carts

Approved [Signature] Director of Maintenance Labor _____ Hrs. _____ Min. _____ \$ _____

Date completed _____ Completed by Tony Mackinley Material: _____

Routine Critical Total \$ _____

For Use By Facility Maintenance Department

Itemized list of material used for repairs. _____

1004 (4/89)

Exhibit 20

Blood Glucose Monitoring

Center Name/Number: _____

License Nurse Name: _____

Blood glucose is monitored to measure the effectiveness of insulin dosage.

Legend: S = Satisfactory Demonstration of Skill

U = Unsatisfactory Demonstration of Skill

Procedure	Date of 1 st Review		Date of 2 nd Review	
	S	U	S	U
1. Check physician's order for blood sugar testing.				
2. Identify resident, provide privacy, and explain procedure.				
3. Don Gloves. Disinfect glucometer prior to each use.				
4. Dilate capillaries, if necessary, by applying warm, moist compresses to the area for approximately 10 minutes.				
5. Wipe the puncture site with an alcohol wipe, and dry thoroughly with a gauze pad.				
6. Position the lancet perpendicular to the lines of the fingertip. <i>Make the puncture on the side of the fingertip.</i>				
7. Pierce the skin sharply and quickly. <i>Alternatively, a mechanical bloodletting device with a spring-loaded lancet may be used.</i>				
8. Wipe away the first drop of blood with a gauze pad, and avoid squeezing the puncture site.				
9. Touch the diagnostic strip to the drop of blood, covering the entire strip. <i>Follow the manufacturer's instructions exactly.</i>				
10. Briefly, apply pressure to the puncture site.				
11. Apply the adhesive bandage to the puncture site, if necessary.				
12. Discard the lancet in a sharps container. Disinfect glucometer after use.				
13. Remove gloves, and wash hands.				
14. Disinfect glucometer per manufacturer's directions. Perform Quality Control testing as directed.				
15. Document results in resident's medical record.				

03/02/06 R

Exhibit 21

Cedars of Lebanon PROXIMITY OF CLEAN CARTS TO DISPOSAL UNIT Monitor							
Circle Answer	Is area clean and free from debris		Trash unit Contained?		If not, Immediate action taken	Comments	Initials
DAY 1	Yes	No	Yes	No			
DAY 2	Yes	No	Yes	No			
DAY 3	Yes	No	Yes	No			
DAY 4	Yes	No	Yes	No			
DAY 4	Yes	No	Yes	No			
DAY 5	Yes	No	Yes	No			
DAY 6	Yes	No	Yes	No			
DAY 7	Yes	No	Yes	No			

14 Nursing Monitor						
DAY 1	Yes	No	Yes	No		
DAY 2	Yes	No	Yes	No		
DAY 3	Yes	No	Yes	No		
DAY 4	Yes	No	Yes	No		
DAY 4	Yes	No	Yes	No		
DAY 5	Yes	No	Yes	No		
DAY 6	Yes	No	Yes	No		
DAY 7	Yes	No	Yes	No		
DAY 8	Yes	No	Yes	No		
DAY 9	Yes	No	Yes	No		
DAY 10	Yes	No	Yes	No		
DAY 11	Yes	No	Yes	No		
DAY 12	Yes	No	Yes	No		
DAY 13	Yes	No	Yes	No		
DAY 14	Yes	No	Yes	No		

Exhibit 22

Performance Improvement Form

(Press TAB or your mouse to maneuver between fields or lines. Do not press "Enter")

Employee name:	Today's date
Department/facility <i>House Keeping</i>	Date of hire:
Position	Supervisor:

REASON FOR COUNSELING/CORRECTIVE ACTION:
- Overall unacceptable cleanliness of facility

HAS THIS CONCERN BEEN PREVIOUSLY DISCUSSED WITH THE EMPLOYEE? LIST ANY PREVIOUS COUNSELING SESSIONS/CORRECTIVE ACTIONS:
Spoke to Kim over last year 4/9 cleanliness.

EXPECTED LEVEL OF PERFORMANCE:
100% Compliance

COUNSELING/ CORRECTIVE ACTION
 (Please mark with 'X')

<input type="checkbox"/> Verbal counseling	<input type="checkbox"/> Extension of orientation period
<input checked="" type="checkbox"/> Written warning	<input type="checkbox"/> Demotion
<input type="checkbox"/> Final written warning	<input type="checkbox"/> Suspension
<input type="checkbox"/> Discharge	<input type="checkbox"/> Other

Exhibit 23

INTRAFACILITY REQUEST FOR REPAIRS OR ALTERATIONS

INSTRUCTIONS: This form is to be filled out in duplicate by the Supervisor of the department making the request. Both requisitions should then be sent to the Director of Maintenance.

Date 8/20/2010 Location Davis/Paley Halls/200 Requested by Robbie Eastman

NATURE OF REQUEST (explain fully) Deep scrub on strip wax and clean all areas especially perimeters of each room with special attention to baseboard areas. Replace tiles as needed.

Approved Tony Wood Labor _____ Hrs. _____ Min. _____ \$ _____
Director of Maintenance

Date completed _____ Completed by _____ Material: _____

Routine Critical Total \$ _____

For Use By Facility Maintenance Department

Itemized list of material used for repairs:

1004 (4/69)

Exhibit 24

INTRAFACILITY REQUEST FOR REPAIRS OR ALTERATIONS

INSTRUCTIONS: This form is to be filled out in duplicate by the Supervisor of the department making the request. Both requisitions should then be sent to the Director of Maintenance.

Date 8/20/2010 Location Davis Hall Show Requested by Robbie Eastman
NATURE OF REQUEST (explain fully) Replace missing and at loose file in the shower room ASHP

Approved _____ Labor _____ Hrs. _____ Min. _____ \$ _____
Director of Maintenance
Date completed _____ Completed by X Tony Matney Material: _____
 Routine Critical Total \$ _____

For Use By Facility Maintenance Department

Itemized list of material used for repairs.

1004 (4/89)

Cedars of Lebanon Nursing Center
Monthly Paint, Wiring, General Wear Inspection
Month

Exhibit 25

A101-1 Paint	Wiring	Gen. Wear	138-1 Paint	Wiring	Gen. Wear
Comment:					
A102-1 Paint	Wiring	Gen. Wear			
A103-1 Paint	Wiring	Gen. Wear	139-1 Paint	Wiring	Gen. Wear
A104-1 Paint	Wiring	Gen. Wear			
A105-1 Paint	Wiring	Gen. Wear	140-1 Paint	Wiring	Gen. Wear
A106-1 Paint	Wiring	Gen. Wear			
A107-1 Paint	Wiring	Gen. Wear	142-1 Paint	Wiring	Gen. Wear
A108-1 Paint	Wiring	Gen. Wear			
A110-1 Paint	Wiring	Gen. Wear	143-1 Paint	Wiring	Gen. Wear
A112-1 Paint	Wiring	Gen. Wear	144-1 Paint	Wiring	Gen. Wear
A114-1 Paint	Wiring	Gen. Wear	145-1 Paint	Wiring	Gen. Wear
A116-1 Paint	Wiring	Gen. Wear	146-1 Paint	Wiring	Gen. Wear
A118-1 Paint	Wiring	Gen. Wear	147-1 Paint	Wiring	Gen. Wear
A119-1 Paint	Wiring	Gen. Wear	148-1 Paint	Wiring	Gen. Wear
A120-1 Paint	Wiring	Gen. Wear	149-1 Paint	Wiring	Gen. Wear
A121-1 Paint	Wiring	Gen. Wear	150-1 Paint	Wiring	Gen. Wear
A122-1 Paint	Wiring	Gen. Wear	Cleanliness of facility:		
A123-1 Paint	Wiring	Gen. Wear	Dinning Room		
A124-1 Paint	Wiring	Gen. Wear	Paint Wiring Gen. Wear		
			Chapel/Activity		
			Paint Wiring Gen. Wear		
			A/C Condensate tubing: Intact or leaking		
			DON/ADON		
A125-1 Paint	Wiring	Gen. Wear	Paint Wiring Gen. Wear		
			Medical Records		
			Paint Wiring Gen. Wear		
134-1 Paint	Wiring	Gen. Wear	Upstairs		
			Paint Wiring Gen. Wear		
134-1 Paint	Wiring	Gen. Wear			
136-1 Paint	Wiring	Gen. Wear	Raley Hall Paint Wiring Gen. Wear		
			Davis Hall Paint Wiring Gen. Wear		
137-1 Paint	Wiring	Gen. Wear			
			Date		
			Signature or Initials		

- Medicare Part B
- Medicaid

Today's Date: ___/___/___

Time: _____

CEDARS PATIENT

OUTPATIENT REQUISITION

Full Legal Name _____ Social Security # _____

Birthdate ___/___/___ Physician Name _____

Laboratory Services

- ABG (Blood Gas)
- ALT (SGPT)
- AST (SGOT)
- B₁₂ and Folate
- Blood Culture
- Carbamazepine (Tegretol)
- Culture _____ Specimen
- CBC, Diff & Platelet Ct.
- Basic Metabolic Panels (CHEM 7)
- Comprehensive Metabolic Panels
- Depakote
- Digoxin
- Dilantin (Phenytoin)
- Ferritin
- Glucose (Fasting)
- Hemoglobin A1c
- Hepatic Profile (liver)
- Lipid Profile
- Magnesium
- Phenobarbital
- Protine (PT)
- PSA
- PTT (APTT)
- Quantitative BCG
- Sed Rate, Westergren
- Theophylline
- U/A (Void _____, CC _____, Cath. _____)
C&S indicated if positive for nitrites or WBC's are greater than 5 for males or 10 for females
- 24 Hr. Urine for _____
- HIV
- Thyroid Panel I (T4, T-Uptake, & T7 [FTI])
- Thyroid Panel II (T4, T-Uptake, & T7 [FTI] & TSH)
- Other _____

Exhibit 27

DX/Complaint: _____

Bill to: **Patient's Insurance**

Fax Results to: (270) 692-9548

