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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185278		10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW HEALTH AND REHABILITATION CENTER	9701 WHIPPS MILL RD. LOUISVILLE, KY 40223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 10/23/12 through 10/25/12 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code survey was conducted 10/23/12 with deficiencies cited at the highest scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) 3.0 Manual, it was determined the facility failed to identify a significant improvement for one (1) of eighteen (18) sampled residents and one unsampled resident. Resident #11's physical and mental condition had improved and this was not captured on the MDS by	F 274	1) MDS Coordinator will complete a full MDS significant change assessment for Resident #11. To be completed by 11/20/2012. 2) MDS staff and Director of Nursing will review each resident to determine if the resident's current status is consistent with the most recent MDS completed for the resident. If there is a noted decline or improvement the resident will be evaluated for a significant change assessment. This will be completed by 11/28/2012.	11-29-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X | TITLE ADMINISTRATOR 11-16-12 | (X6) DATE 12-7-12

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

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F 274	Continued From page 1 assessment. The findings include: ~~Review of the RAI 3.0 Manual revealed a~~ Significant Change was a decline or improvement in a residents status. Improvement in two or more of the following areas include: any improvement in an Activity of Daily Living (ADL) physical functioning area where a resident was newly coded as independent, supervision, or limited assistance since last assessment. Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases. The resident's decision making changed for the better. The resident's incontinence pattern changed for the better and the overall improvement of the resident's condition improved. Record review revealed the facility admitted Resident #11 on 03/14/12 with diagnoses of Pressure Ulcer, Fracture of the Femur, Fall, Acute Subdural Hematoma, Dementia, Hypertension, Diabetes, Dyslipidemia, Acute Kidney Injury with Chronic Kidney Disease Stage III, Coronary Artery Disease, Thyroid Goiter, Obesity, Hypothyroidism, Anemia, Alzheimer's and Gastroesophageal Reflux Disease. Review of Resident #11's Admission MDS, dated 03/21/12, and the Quarterly MDS, dated 09/13/12, revealed Resident #11 improved from a score of 5 to a score of 11 on the Brief Interview for Mental Status (BIM). The resident improved from a score of 8-8 activity did not occur in ambulation to a 3-2 indicating extensive assistance with one person. Dressing improved	F 274	3) The facility Corporate Consultant will review the ~~Guidelines for a Significant~~ Change Assessment with ~~the MDS staff. This will be~~ completed by 11/26/2012. This education will be provided again to the MDS staff in 3 months then will be reviewed no less than annually. This education will be provided to any newly hired MDS staff by the Corporate Consultant during orientation. 4) The DON will review 25% of all Assessments completed each Week for 4 weeks to be Completed by 12/17/2012 then 25% of All assessments completed monthly for 2 months to determine that Significant Change Assessments are being completed as indicated. After the initial quarter of reviews the DON will review 10% of all MDS Assessments completed quarterly and will report findings to the Facility QA Committee.	

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F 274	Continued From page 2 from a 4-3 which meant total dependence of two person assist to a 3-2 extensive assist of one person. Eating improved from a 3-2 which meant extensive assistance with one person assist to a 1-2 supervision with one person assist. Hygiene and bathing improved from a 4-3 and 4-2 which meant total dependence with one to two person assist to 3-2 extensive assist with one person assist. Bowel continence improved from a 3 which meant always incontinent to a 1 occasionally incontinent. Resident #11 was assessed with a pressure wound and improved as it was healed on the quarterly. Interview with Certified Nursing Assistant (CNA) #1, on 10/25/12 3:26 PM, revealed Resident #11 was not walking when he/she was first admitted and could barely stand. CNA #1 stated Resident #11 could now ambulate with a walker with a one person assist. CNA #1 stated Resident #11's cognition and incontinence had improved. Interview with the West Unit Manager, on 10/25/12 at 2:27 PM, revealed Resident #11 had definitely had some improvement because he/she was admitted with a fracture. Resident #11's Activity of Daily Living improved and he/she participates better in activities. The West Unit Manager stated when it came to Resident #11's cognition Resident #11 had improved and at times he/she was really alert and less confused. Resident #11's ambulation had improved as well because he/she now walks with a walker with one assist. Interview with the Assistant Director of Nursing (ADON), on 10/25/12 at 3:20 PM, revealed she had seen an improvement for Resident #11 and	F 274	4) [illegible]	

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F 274	Continued From page 3 was aware that all of Resident #11's wounds were healed.	F 274		
	~~Interview with the MDS Coordinator, on 10/25/12~~ at 2:46 PM, revealed she was aware a significant change on improvement occurred when two or more improvements occurred on the MDS. The MDS Coordinator stated she had completed a significant change based on improvement before and stated a significant change on Resident #11 should have occurred.			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	1) The MDS Coordinator reviewed care plan for Resident # 12 on 10-25-12 and a care plan was developed related to dialysis, then the MDS Coordinator reviewed care plan for resident #3 on 10-25-12 and a care plan for the g-tube was developed.	11-27-12

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F 279	Continued From page 4 by: ~~Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a comprehensive care plan for two (2) of eighteen~~ (18) sampled residents and one (1) unsampled resident, Residents #3 and #12. The facility failed to address interventions for care and treatment of Resident #12's hemodialysis and Resident #3's care and treatment of a G-tube. The findings include: Review of the facility's Hemo-dialysis Resident Care, Additional Procedures, effective 11/08, revealed to provide the purpose of the manual was to ensure the provision of the necessary care and treatment of resident's receiving hemo-dialysis. Interview with the Assistant Director of Nursing (ADON), on 10/25/12 at 3:20 PM, revealed initial care plans were completed by the nursing staff. The MDS Coordinators were responsible for the printed care plans that were completed after the initial assessment. The ADON stated if the resident came into the facility with Dialysis then there should be a plan of care completed. The ADON further stated there were care plans in place to direct the care that needs to be given. Any nurse should be able to come in to the facility, read the plan of care and provide care accordingly. Review of the clinical record revealed the facility admitted Resident #12 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus II, Hyperlipidemia, Diabetic	F 279	2) All comprehensive care plans to be reviewed by the care plan IDT to ensure that all needs are addressed and ~~that all care plans are current~~ and applicable to the resident. Any updates or revisions will be completed as indicated and to be completed by 11/26/2012 3) Nursing staff including care plan IDT will be reeducated by the Director of Nursing on the use of the care plan to direct care and the need to include special procedures on the individual care plan on 11/20/12. Beginning 11/19/12 each Unit Manager will receive and review all MD orders to ensure any specialized service or change in orders are included in the care plan. The initial care plan will be reviewed by the Unit Managers after completion, to ensure all specialized services are noted on the care plan.	

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F 279	Continued From page 5 Retinopathy, Chronic Heart Failure, Obstructive Sleep Apnea, Morbid Obesity, Pilonidal Cyst removal in the past, and End Stage Renal Disease on 09/08/12. Review of the Minimum Data Set (MDS), Admission Assessment, completed on 10/12/12 revealed Resident 12 was coded as receiving Dialysis Services. Review of the CAA's for falls, revealed the admission assessment was checked for dialysis and Resident #12 was to receive Dialysis treatment three times a week. Review of the care plans revealed no care plan could be found that addressed the treatment of Dialysis. Interview with the West Unit Manager, on 10/25/12 at 2:27 PM, revealed Resident #12 had been receiving dialysis since he/she was admitted to the facility. The nurses initiate the acute care plans and then the MDS team completes the care plans once the initial assessment was completed. If Resident #12 triggered for dialysis then there should be a care plan present. The West Unit Manager further stated it was everyone's responsibility to care plan and update the care plan as needed. Interview with the MDS Coordinator, on 10/25/12 at 2:46 PM, revealed Resident #12 was receiving dialysis. The MDS Coordinator stated there should be a care plan present for dialysis. During the care plan meeting staff check to see that all the care plans have been made up-to-date. The MDS Coordinator stated there were risks of complications of dialysis for Resident #12 and there should have been plans of care in place to address before and after dialysis was provided to Resident #12. The MDS Coordinator stated she could not say if the nurses would know what type	F 279	5 4) DON to review 25% of care plans developed each week for 4 weeks to be completed by 12/17/12, then 10% each ~~month for 2 months then will continue~~ to review 10% of care plan each quarter as part of the ongoing QA process. Findings will be reported to the facility QA for review.	

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F 279	Continued From page 6 of care to provide if there was no care plan provided. The dialysis care plan would be one she would generate after the assessment was completed and did not know how she could have missed it.	F 279		
	Interview with the Assistant Director of Nursing (ADON), on 10/25/12 at 3:20 PM, revealed initial care plans were completed by the nursing staff. The MDS Coordinators were responsible for the printed care plans that were completed after the initial assessment. The ADON stated if the resident came into the facility with Dialysis then there should be a plan of care completed. The ADON further stated there were care plans in place to direct the care that needs to be given. Any nurse should be able to come in to the facility, read the plan of care and provide care accordingly.	3)		
	Review of the medical record revealed the facility admitted Resident #3 on 07/18/12 with a gastrostomy tube (G-tube), and diagnoses of Acute Kidney Failure, Chronic Blood Loss, Malnutrition, Hypothyroidism, Advanced Dementia, and a history of Pneumonia. Resident #3 received bolus feedings of Glucerna 1.5 five (5) times daily per a g-tube. The Minimum Data Set (MDS) completed on 09/03/12, revealed a feeding tube was a triggered care area within the Care Area Assessment Summary (CAAS). The comprehensive care plan revealed water flushes per G-tube was an intervention under the Dietary component of the care plan, but no other interventions for G-tube care were listed.			

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F 279	Continued From page 7 Observation, on 10/24/12 at 9:45 AM, during the skin assessment revealed Resident #3 had a G-tube tube in place covered by a split 4 x 4 gauze dressing. Licensed Practical Nurse (LPN) #4 stated G-tube care was given every shift. Interview, on 10/25/12 at 2:15 PM, with the MDS Coordinator revealed there should have been a care plan for Resident #3's G-tube. The problem with not care planning the G-tube would be the potential for inconsistent delivery of nutritional support or a lack of proper G-tube care across all shifts. The MDS coordinator pointed out that Resident #3's care plan was reviewed by the Interdisciplinary Team (IDT) on 10/24/12. The MDS coordinator stated she was responsible for ensuring a comprehensive care plan was developed and/or revised by the IDT based on triggers identified in the CAAS, the resident's diagnoses, or any changes in condition. Interview, on 10/25/12 at 4:00 PM, with the Assistant Director of Nurses (ADON), revealed G-tube interventions should have been in Resident #3's comprehensive care plan. The MDS coordinator and the IDT were responsible for ensuring the care plan addressed all areas of the resident's care.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 8	F 280		
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to revise the comprehensive care plan for one (1) of eighteen (18) sampled residents and one unsampled resident, Resident #3, related to the care and maintenance of an indwelling urinary catheter. The findings include: Review of the Resident Assessment Instrument (RAI) Process and Care Planning Policy, dated 05/20/99, revealed the purpose of the RAI and care planning process was to ensure quality resident care was provided by all staff. The RAI coordinator would oversee the completion of an interdisciplinary and comprehensive resident		1) The care plans for Resident # 3 were reviewed by the MDS Coordinator. The development of a care plan related to the indwelling foley catheter including, but not limited to, its care and maintenance was completed on 10/25/12.	11-27-12

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F 280	Continued From page 9 assessment with care plan development, implementation, and continued evaluation. Care plans would be used by all staff and would be updated to reflect all necessary care. Nursing and Certified Nursing Assistant (CNA) assignments would be given based on the care plan, and resident care would be provided based on the information gained though the RAI/care planning process. Review of the clinical record revealed the facility admitted Resident #3 on 07/18/12 with diagnoses of Acute Kidney Failure, Chronic Blood Loss, Malnutrition, Hypothyroidism, Advanced Dementia, and a history of Pneumonia. Review of the Care Area Assessment Summary (CAAS) of the Minimum Data Set (MDS), dated 09/03/12, revealed Resident #3 triggered for urinary incontinence/indwelling catheter, and indwelling catheter was coded as an appliance under section H of the MDS. Review of the Comprehensive Care Plan revealed interventions for incontinence care; but, there were no interventions listed for the care and maintenance of Resident # 3's indwelling catheter. Observation, on 10/23/12 at 8:45 AM, revealed Resident #3 had an indwelling catheter connected to a bedside drainage bag. Observation, on 10/24/12 at 9:45 AM, during the skin assessment revealed Resident #3 had an indwelling catheter draining clear yellow urine into a catheter bag attached to the bedside. Interview, on 10/25/12 at 10:30 AM, with the East Hall Unit Manager revealed nurses were responsible for updating care plans during	F 280	2) All comprehensive care plans to be reviewed by the care plan IDT to ensure that all needs are addressed and that all care plans are current and applicable to the resident. Any updates or revisions will be completed as indicated by 11/26/12.	/12

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F 280	Continued From page 10 readmission of a resident after a brief hospitalization and whenever appropriate upon receipt of MD orders. The IDT would be informed of changes to the care plan during daily morning staff meetings. Interview, on 10/25/12 at 2:15 PM, with the MDS Coordinator revealed Resident #3's care plan should have been updated to reflect catheter care interventions. The MDS coordinator indicated the problem with not care planning the catheter would be the potential for inconsistent care across all shifts resulting in infection or other catheter related complications. She also stated the unit nurses were responsible for updating the care plan upon receipt of MD orders, and would apprise other staff members of the changes during morning staff meetings. The MDS coordinator further stated she was responsible for ensuring a comprehensive care plan was developed and revised by the IDT based on triggers generated in the CAAS section of the MDS, the resident's diagnoses, or any changes in the resident's condition. The MDS coordinator pointed out Resident #3's care plan was last reviewed on 10/24/12 by the IDT, but catheter care interventions were not added. Interview, on 10/25/12 at 4:00 PM, with the Assistant Director of Nurses (ADON) revealed indwelling catheter care interventions should have been in Resident #3's comprehensive care plan. She stated the MDS coordinator and the IDT were responsible for ensuring the care plan addressed all areas of resident care. The ADON further stated the unit nurses were responsible for updating the care plan when new MD orders were received, and the IDT would update the care plan		3) Nursing staff including care plan IDT will be reeducated by the Director of Nursing on the use of the care plan to direct care and the need to include special procedures on the individual care plan. They will also be reeducated by the Director of Nursing on the importance of reviewing the care plan upon readmission from a short hospital stay to ensure specialized services are noted on the care plan. Each unit manager will review the care plans of patients that return to the facility from short hospitalizations. To be completed by 11/20/12 4) DON to review 25% of care plans developed each week for 4 weeks to be completed by 12/17/12, then 10% each month for 2 months then will continue to review 10% of care plans each quarter as part of the ongoing QA process. Findings will be reported to the facility QA Committee for review. the	

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F 280	Continued From page 11	F 280		
F 281 SS=D	based on MDS quarterly reviews. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		
	The services provided or arranged by the facility must meet professional standards of quality.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with professional standards of practice. An expired dose of intravenous (IV) antibiotic medication was administered to one (1) of eighteen (18) sampled residents and one (1) unsampled resident, Resident #4.		1) On 10/23/12 LPN # 1 was reeducated by the Director of Nursing on the importance of checking medication expiration dates prior to administering the medication. Resident #5 was monitored every shift for 24 hours monitoring for any adverse affects of the administered IV antibiotic. Resident #5 showed no signs or symptoms of any adverse affects.	11-21-12
	The findings include:			
	Review of the facility's policy regarding Preparation and General Guidelines, Medication Administration revealed: Medications are administered as prescribed in accordance with good nursing principles and practices.		2) The DON checked all other medications in the building for expired drugs on 10/23/12 to ensure that no other resident would be given an expired med. No expired medications were found.	
	Observation of Resident #4, on 10/23/12 at 3:00 PM, revealed an IV pump at the bedside with the IV tubing and empty IV medication bag hanging but not connected to Resident #4's IV access. The empty medication bag hanging was dated as expired on 10/22/12 at 11:00 PM.			
	Review of the record for Resident #4 revealed the facility admitted the resident on 09/13/11 with			

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F 281	Continued From page 12 diagnoses to include Urinary Retention with Neurogenic Bladder. The facility assessed Resident #4 as having a cognition score of fifteen (15) on the Minimum Data Set resident evaluation form. Resident #4 was prescribed an IV antibiotic for a urinary tract infection to start on 10/18/12 and to end on 10/24/12. Review of the medication administration record for Resident #4 revealed he/she had received a 10:00 AM dose of the IV antibiotic on 10/23/12. Review of a medication pass form used by the pharmacy consultant, when doing medication pass observations for the facility's newly hired nurses and certified medication technicians, revealed the pharmacist would check to see if the nurse being observed checked medications to ensure he/she did not administer an expired medication. Review of a facility training record revealed the nurse who was responsible to administer the 10:00 AM dose of the IV medication to Resident #4 on 10/23/12 (LPN #1) had been trained on medication pass on 01/23/12. Interview with LPN #1, on 10/25/12 at 10:05 AM, revealed she did administer the IV antibiotic to Resident #4, on 10/23/12 at 10:00 AM, and the bag observed hanging on that date at 3:00 PM was the bag of medication she had administered. She stated she now knew the medication was expired and she knew she should not have administered an expired medication. She further stated she had checked and double-checked that she had the right medication for the right resident but she had failed to note the expiration date. She stated the pharmacy would usually remove expired medications from the medication room and medication carts but she knew that was no excuse for her not to check the expiration date.	F 281	3) The clinical educator will re-educate the nursing staff responsible for administrating medications on the importance of checking expiration dates prior to administration on November 20th and will repeat this education monthly for 3 months then include this in an annual in-service on medication administration. All newly hired nurses will be educated on the medication administration process during orientation by the Clinical Educator.	

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F 281	Continued From page 13 LPN #1 stated she had been trained on medication pass at the facility. She stated she had not been observed passing medications since her hire at the facility two (2) and one-half (1/2) years ago. Interview with the Consultant Pharmacist (RPh), on 10/24/12 at 4:00 PM, revealed the expired IV medication Resident #4 received would not harm him/her but it may have reduced potency. She explained she would be more concerned if the resident received that dose at the beginning of the antibiotic therapy, but as it was nearly completed it probably would not affect the efficacy of the medication for the resident's urinary tract infection. She further explained the antibiotic prescribed for Resident #4 had a short life after admixture and that probably accounted for the expired IV medications being in the medication room. However, she did state the nurses should always check for medication expiration dates and not administer any expired medication. The RPh indicated the pharmacy was involved in medication pass observations for the facility for newly hired nurses and certified medication technicians but they did not conduct random medication pass observations of the nursing staff. She stated she was not aware of any on-going concerns with medication errors in the facility and she attended the quarterly quality assurance committee meetings. Interview with the Assistant Director of Nursing (ADON), on 10/25/12 at 10:20 AM, revealed the facility did an orientation for nursing staff upon hire with a medication pass observation by the pharmacist but the nursing department and the pharmacist did not conduct any random		4) The clinical Educator with the assistance of our Pharmacy Consultant will perform a medication pass observation of the nursing staff responsible for administrating medications quarterly for 2 quarters then no less than annually to ensure appropriate technique in administering medications including checking expiration dates prior to administration. These observations will be used as a basis for re-education as indicated. DON will report outcome of medication pass observations to the facility QA Committee 1/2013 for review of compliance and/or the need for changes to POC. To assure expired medications are not utilized by staff prior to the QA meeting, the 3rd shift CMT/Nurses responsible for medication carts will audit medications weekly for any expired meds and dispose of them per facility protocol.	11-20-12

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F 281	Continued From page 14 medication pass observations. She stated the nurses and certified medication technicians were shown a medication pass video during their orientation. The ADON indicated she knew it was a nursing standard of practice for nurses and certified medication technicians to check all medications for the expiration date and to not administer any medication which was expired. Interview with the Administrator during the quality assurance interview, on 10/25/12 at 4:00 PM, revealed the facility's medication error rate was low and she was not aware of problems with administration of expired medications in the facility.	F 281		
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	F 431		

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F 431	Continued From page 15 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure medications were securely stored in the medication cart. One (1) of four (4) medication (med.) carts had two (2) bottles of eye drops left on the top of the med. cart for several minutes and the med. cart was left unlocked and unattended during the medication pass for several minutes. The findings include: Review of the facility's policy regarding Medication Storage in the Facility, dated 02/01/10, revealed medications intended for internal use were stored in a med. cart and the med. cart should be locked or attended by someone with authorized access, including licensed nurses. Review of the facility's policy regarding Equipment and Supplies for Administering	F 431	1) On 10/24/12 the Director of Nursing verbally re-educated RN # 2 which included instruction for securing eye drops inside of the medication cart and the importance of not leaving the medication cart unlocked when it is out of her sight. 2) On 10/24/12 DON and ADON Checked all medication carts no less than 2x per shift to ensure the medication carts were locked and all medications were stored appropriately.	11-21-12

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F 431	Continued From page 16 Medications, dated 02/01/10, revealed the medication cart should be kept locked when out of sight of the medication nurse. Additionally, no medications (meds.) should be kept on top of the cart. The cart must be inaccessible to residents or others passing by. Review of the Nurse Orientation Checklist revealed the med. pass skill was listed for return demonstration or verbalization of the skill or process. Observation, on 10/24/12 from 8:15 AM through 8:50 AM, revealed Registered Nurse (RN) #2 left the unlocked medication cart out of view. Additionally, two (2) bottles of eye drops were observed stored on top of the med. cart from 8:15 AM until 8:43 AM with one bottle to be administered at 8:30 AM and the second bottle to be administered at 8:43 AM. Continued interview with RN #2, on 10/24/12 at 8:50 AM, revealed the eye drops were left on the top of the med. cart as they needed to be administered several minutes apart and she did not want to forget to give them. Additionally, she stated the med. cart should be kept locked when administering medications. RN #2 stated she had been trained by the facility on med. pass and the med. cart but had forgotten to lock it. RN #2 further stated leaving the med. cart unlocked and the eye drops on the top of the cart allowed residents the opportunity to take the medications off the cart but could also ingest them. On 10/25/12 at 9:45 AM, interview with the Unit Manager (UM) revealed medications should not be stored on the top of the med. cart and the med. cart should have been locked when the		3) The clinical educator will re-educate the nursing staff responsible for administrating medications, on the importance of ensuring the medication carts are locked and that all medications are properly stored. Beginning on 11/19/12 the Unit Managers will perform daily rounds, checking all medication carts ensuring that all medications are secured when out of sight of the person assigned to that cart. The second shift house Supervisor will also be assigned to do the same. They will re-educate the nursing staff as indicated which will include instruction for securing all medications inside of the medication cart and the cart to remain locked when it is out of their sight. 4) The Clinical Educator with the assistance of our Pharmacy Consultant will perform a medication pass observation of the nursing staff responsible for administrating medications beginning on 12/4. The results will be given to the Administrator for review for compliance and/or the need for changes in the POC. The clinical educator will present the results to the QA committee 1/2013. This POC will be done for 2 quarters then no less than annually ensuring the medication carts are locked and all medications are stored appropriately.	11-19-12

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F 431	Continued From page 17 nurse walked away from it. The UM stated nurses were trained in orientation with another nurse or the Staff Development Coordinator regarding how to pass meds and use of the med. cart. She stated she monitored med. pass and the med. carts with spot checks when walking down the hall. The UM stated if a med. cart was found unlocked she would lock the cart. The UM stated the facility had residents with confusion on the west and east wings and anyone could have access to the meds. if they were not secured. She stated if a resident took meds. from the cart and ingested them, the resident could have multiple problems and poison control would need to be contacted. Interview, on 10/25/12 at 11:30 AM, with the Staff Development Coordinator/ Wound Care Nurse revealed medications should not be stored on top of the med. cart and the med. cart should be locked when the nurse stepped away from it. The Staff Development Coordinator stated nurses were trained on the med. cart during orientation, including locking the cart and not leaving meds. on the top of the cart. She stated the orientation on the floor was conducted by a nurse preceptor who also documented on the orientation checklist the orienting nurse had completed the med. pass process. She stated there were no specific preceptors to train new nurses and it was usually completed by more seasoned nurses. The Staff Development Coordinator stated there was no way to know if a preceptor was qualified to train new nurses. The Staff Development Coordinator stated she did not monitor or spot check the units however if a concern was brought to her attention she would address it at that time. She stated med. carts were found unlocked in the facility	F 431		

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F 431	Continued From page 18 daily for the last month. She stated there had been no new training or monitoring put in place since the increase in unlocked med. carts. She stated if a med. cart was unlocked or meds. left on top of the med. cart while unattended by the nurse anyone in the facility could take the meds. If the meds. were ingested the resident could have an allergic reactions or become sick. Interview with the Assistant Director of Nursing (ADON), on 10/25/12 at 1:40 PM, revealed meds. should be in the med. cart and secured by the lock when the nurse walked away. She stated meds. should not be stored on the top of the med. cart. The ADON stated new nurses were trained on the floor with another nurse or the Staff Development Coordinator and the pharmacy would also follow a new nurse orientee. She stated med. pass in-service was also conducted yearly. The ADON stated concerns would be identified when any of the unit managers or administrative staff were walking down the hall and noticed if a med. cart was unlocked. She stated storing meds. on top of the cart and leaving the med. cart unlocked would allow anyone to have access to the cart. She stated there were confused residents in the facility and it was possible for a resident to ingest medications if the meds. were not securely locked, which could lead to various problems for the resident depending on the medication.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 20 practices related to hand hygiene for five (5) of eighteen (18) sampled and one (1) un-sampled resident. Hands were not washed and/or gloves were not changed for Residents #1, #3, #5, #9, and #10 during skin assessments, and Resident #5 during a dressing change. Additionally during blood sugar accu-checks for Residents #9 and Un-sampled A, the site for obtaining the blood sample was re-contaminated by the nurse prior to specimen sampling. The findings include: The facility did not provide a policy for hand hygiene. Review of the Centers for Disease Control (CDC) Handwashing Guidelines, dated 10/25/2002, revealed hands should be decontaminated prior to direct contact with patients, when moving from a contaminated to clean body site, and after wound dressings. Additionally, when hands were washed a towel should be used to turn off the water. Review of the Nurse Orientation Checklist revealed skin assessments and hand hygiene were not listed as a part of the new employee orientation training. 1. Observation, on 10/24/12 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #5 did not wash her hands after applying a treatment to Resident #1's buttocks and peri area and before touching the resident's face. After the skin assessment had been completed and prior to a dressing change, the nurse washed her hands and turned off the water with her bare hands.	F 441	1) Residents # 1, #3, #5, #9 and #10 have been monitored for any signs of infection, or skin irritation as a result of improper hand hygiene during the observed skin assessments. In addition there is no signs of infection at the G-tube site nor the wound on the toe of Resident #5 as a result of improper hand hygiene during the treatments. Resident #9 has not experienced any adverse effects from the contamination of the blood sample site. 11-21-12	

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F 441	Continued From page 21 2. Observation, on 10/24/12 at 11:50 AM, revealed LPN #5 applied a clean brief and cleaned Resident #10's buttocks and peri area during a skin assessment. LPN #5 then continued with the skin assessment, moving up the resident's body to the back, arms, and face. Continued observation, on 10/24/2012 at 2:40 PM, of a skin assessment for Resident #10, revealed LPN #5 washed her hands prior to conducting the skin assessment and turned the water off with her bare hands. During the skin assessment, the nurse did not wash her hands after assessing the resident's peri area and buttocks. The nurse assessed the resident's face and head last. Interview, on 10/24/12 at 3:10 PM, with LPN #5 revealed when washing hands the water should be turned off with a paper towel, not bare hands. She stated she should change her gloves after touching a resident's peri area or buttocks, and she should wash her hands whenever she changed her gloves. She stated she had been trained by the facility in hand hygiene. The LPN stated not changing gloves or washing hands could spread infection to the residents. Interview, on 10/25/12 at 10:15 AM, with the Unit Manager (UM) revealed water should be turned off with a paper towel, not bare hands. The UM stated the nurse should wash hands and change gloves prior to conducting a skin assessment, after touching the peri area, changing a resident's soiled brief, and anytime moving from a dirty to a clean area on the resident's body. She stated the resident was at risk for infection, and there was the potential to introduce infection to another	F 441	2) DON reviewed all skin assessments, 11/2/12 to determine if there were any signs of infection, or deterioration in current wounds that could be attributed to improper hand hygiene during skin assessments.	

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F 441	Continued From page 22 resident. The UM stated nurses were trained during orientation on the unit with another nurse and had in-service training yearly. She stated she did not monitor hand hygiene practices. Interview, on 10/25/12 at 11:30 AM, with the Staff Development Coordinator/Wound Nurse, revealed water should be turned off with a paper towel and hands should be washed between glove changes, and before and after providing care. She stated turning off the water with bare hands could re-contaminate the hands and spread infection. She stated nurses were trained in orientation by a floor nurse in hand hygiene and an in-service training was conducted annually at a health fair, which included return demonstrations. The Staff Development Nurse stated she did not monitor hand hygiene and only addressed concerns that had been brought to her attention. Interview, on 10/25/12 at 1:40 PM, with the Assistant Director of Nursing (ADON) revealed hands should be washed upon entering a resident's room and any time gloves were changed. She stated gloves should be changed when peri care had been given and after changing a resident's brief. Hands should be washed after completing a resident's care, and a paper towel should be used to turn off the faucet after washing hands. The ADON stated not washing hands, changing gloves, or turning off the faucet with bare hands had the potential to spread infection. She stated the UM was responsible to monitor hand hygiene. The facility did not provide a policy on dressing changes.	F 441	3) All current nursing staff will be re-educated on correct hand hygiene during dressing changes, skin assessments, and accu-checks. All new nursing staff employees will be checked off by performing a return demonstration of infection control practices during skin assessments, dressing changes, and accu-checks as part of their orientation process. 4) The clinical educator will observe each nursing employee performing infection control activities quarterly for two quarters then no less than annually. The clinical educator will give written results to the Director of Nursing. The clinical educator will advise nurses as needed to ensure infection control guidelines are being followed. The audit results will be presented to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed.	11-20-12

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F 441	Continued From page 23 Review of the Nurse Orientation Checklist revealed dressing changes were not listed as part of the orientation process. Interview, on 10/25/12 at 1:40 PM, with the ADON revealed gloves should be changed and hands washed when caring for an open wound, including after removing a soiled dressing and prior to placing a clean dressing. She stated the nurse's soiled hands and gloves had the potential to carry bacteria to an opening into the body, including an open wound. The ADON stated nurses were trained in orientation and yearly in-services with return demonstration. She stated the Staff Development Nurse/Wound Nurse monitored dressing changes with spot checks. The ADON stated the facility did not have a policy on dressing changes. 3. Review of the clinical record revealed the facility admitted Resident #5 on 09/15/11 with a diagnosis of Dementia. The comprehensive Minimum Data Set (MDS), dated 09/09/12, revealed the resident had a Brief Interview Mental Status (BIMS) score of three (3) and was cognitively impaired. The resident had a feeding tube (G-tube) that had been removed. The resident was care planned for wound treatments per the physician order. Observation, on 10/24/2012 at 2:40 PM, revealed LPN #5 cleaned and treated a wound to Resident #5's toe. LPN #5 then cleaned and applied treatment to the G-tube site without washing her hands or changing her gloves after caring for the resident's toe and prior to beginning care of the G-tube site.	F 441		

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F 441	Continued From page 24 Interview, on 10/24/12 at 3:10 PM, with LPN #5 revealed she should have changed her gloves and washed her hands between wounds and she had been trained how to conduct a dressing change. The LPN stated not changing gloves or washing hands put the resident at risk for cross contamination. Interview, on 10/25/12 at 10:15 AM, with the Unit Manager (UM) revealed during a dressing change hands should be washed and gloves changed when moving from one area to another. She stated the resident was at risk for the spread of infection during a dressing change. The UM stated nurses were trained on the floor by other nurses during orientation and completed return demonstration. Additionally, in-services were conducted annually, including an annual health fair. The UM stated she does not monitor dressing changes and would only observe a dressing change if a concern was brought to her attention. Interview, on 10/25/12 at 1:40 PM with the ADON revealed gloves should be changed and hands washed when caring for an open wound, including after removing a soiled dressing and prior to placing a clean dressing. She stated the nurse's soiled hands and gloves had the potential to carry bacteria to an opening into the body, including an open wound. The ADON stated nurses were trained in orientation and yearly in-services with return demonstration. She stated the Staff Development Nurse/Wound Nurse monitored dressing changes with spot checks. The ADON stated the facility did not have a policy on dressing changes.	F 441		

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F 441	Continued From page 25 The facility failed to provide a policy for obtaining accu-checks. Review of the Nurse Orientation Checklist revealed accu-check procedures, including obtaining and cleaning procedures was listed as a return demonstration or verbalization of the skill or process. 4. Observation, on 10/24/12 at 11:10 AM, revealed LPN #4 during an accu-check for Un-sampled Resident A, cleaned the resident's finger- tip with an alcohol wipe and then immediately wiped the alcohol off the resident's finger with her gloved hand. The nurse then took the blood sample from the resident's finger tip. The LPN was again observed, at 11:20 AM, obtaining an accu-check for Resident #9 with the same procedure. Interview, on 10/24/12 at 11:25 AM, with LPN #4 revealed she always wiped the resident's cleaned site with her gloved hand until the resident's finger tip was dry. The LPN stated she did not want the excess alcohol on the resident's finger as it could skew the test result. She stated if she had touched something with the glove prior to the accu-check then there was the potential to have a contaminated glove and could contaminate the skin that had just been cleaned. Interview, on 10/25/12 at 11:30 AM, with the Staff Development Coordinator/Wound Nurse revealed after cleaning the site with the alcohol wipe the area should not be wiped but should be allowed to air dry. She stated wiping the area with the nurse's glove after the area had been cleaned would re-contaminate the site. The Staff	F 441		

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F 441	Continued From page 26 Development Coordinator stated the nurse's glove could easily become soiled and wiping the area with her glove could be a point of entry for infection to the resident. She stated nurses were trained during orientation the procedure to obtain accu-checks, including obtaining the blood sample. She stated the orientation on the floor was conducted by a nurse preceptor who also documented on the orientation checklist the orienting nurse had completed the accu-check process. She stated there were no specific preceptors to train new nurses and it was usually completed by more seasoned nurses. The Staff Development Coordinator stated there was no way to know if a preceptor was qualified to train new nurses. The Staff Development Coordinator stated she did not monitor or spot check accu-check procedures; however, if a concern was brought to her attention she would address it at that time. Interview, on 10/25/12 at 1:40 PM, with the ADON revealed the nurse should not touch the resident's finger after it had been cleaned with an alcohol wipe. She stated the finger should dry to air. The ADON stated nurses were trained in orientation how to conduct an accu-check in addition to annual in-services. She stated monitoring was conducted on the spot by the unit managers. The ADON stated wiping the cleaned finger- tip with a gloved hand could introduce bacteria to the site, which could lead to infection for the resident. 5. Review of the clinical record revealed the facility admitted Resident #3 on 07/18/12 with diagnoses of Acute Kidney Failure, Chronic Blood Loss, Malnutrition, Hypothyroidism, Advanced Dementia, and a history of Pneumonia. The	F 441		

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F 441	Continued From page 27 resident had a G-tube for bolus feedings and an indwelling catheter. Observation, on 10/24/12 at 9:45 AM, revealed LPN #3 did not wash her hands prior to donning gloves to perform the skin assessment for Resident #3. During the assessment, LPN #3 opened the resident's brief, touched the peri area, then proceeded with the assessment touching Resident #3's legs and back without removing her gloves, washing her hands, and donning clean gloves after touching the perineum. In addition, LPN #3 did not wash her hands after completing care for Resident #3. Interview, on 10/24/12 at 12:45 PM, with LPN #3 revealed she should have washed her hands before beginning Resident #3's skin assessment, and before exiting the resident's room. In addition, she should have washed her hands and changed gloves after touching Resident's #3 perineum. LPN #3 stated the potential problem with not observing proper hand hygiene before and after giving direct care would be the spread of infection.	F 441		

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1970 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story and a partial basement, Type III (000) SMOKE COMPARTMENTS: Five (5) FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed. GENERATOR: Type II generator installed in 2010. Fuel source is diesel. A standard Life Safety Code survey was conducted on 10/23/12. Meadowview Health and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et. seq. (Life Safety from Fire). Deficiencies were cited with the highest	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: X ADMINISTRATOR X — (X6) DATE: ~~11-16-12~~ 12-7-12

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

12-10-12

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K 000	Continued From page 1 deficiency identified at "E" level.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was eighty-six (86) on the day of the survey. The findings include: Observation, on 10/23/12 at 12:00 PM, with the Maintenance Director revealed the door to the Medical Records Room adjacent to Resident Room 30, did not have a self-closing device installed on the door.	K 029	K29 A self closing device was installed on the door to the mechanical room and Medical Records office on 11-12-2012 by the Dir. of Maintenance. All other doors were checked to determine if a self closing device was required and working properly. One additional door was found to need a self closing device and it was installed on 11-12-2012 by the Dir. Of Maintenance. A check of all self closing doors has been added to the Preventative maintenance program to be completed monthly. This was added on 11-15-2012. All self closing doors were checked, on 11-15-2012, and all found to be in proper working order. Doors to both dry storage areas will be installed, by the Dir. of Maintenance. The doors have been ordered, (see attached invoice dated 11-30-2012). Both doors will be one hour fire rated with self closing latches. Inspection of these doors will be added to the monthly Tells, preventative program. The Tells preventative program is reviewed monthly by the Dir. of Maintenance and the Regional Facilities manager. Results are reviewed by the facility Administrator on a monthly basis, and findings are reviewed at the monthly safety committee and quarterly Quality Assurance committee. This review is completed monthly and is ongoing.	11-30-12

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K 029	Continued From page 2 Interview, on 10/23/12 at 12:00 PM, with the Maintenance Director revealed the Medical Records Room had previously been converted from an Office, a non-hazardous classification, not requiring a self-closing device. Observation, on 10/23/12 at 1:52 PM, with the Maintenance Director revealed the door to the Mechanical Room, located in the basement, was not equipped with a self-closing device. Interview, on 10/23/12 at 1:52 PM, with the Maintenance Director revealed the door to the Mechanical Room had never been equipped with a self-closing device, but was always closed and locked. The partial basement is used for Maintenance, Mechanical and Laundry, occupied by Staff only Observation, on 10/23/12 at 2:15 PM; with the Maintenance Director revealed the Kitchen had two (2) separate Dry Storage Rooms. Both of the rooms were open to the Kitchen and not separated with doors equipped with self-closing devices. Interview, on 10/23/12 at 2:15 PM, with the Maintenance Director revealed the two (2) separate Dry Storage Rooms had never had doors with self-closing devices installed. Further interview, on 10/23/12 at 4:45 PM, with the Administrator and the Maintenance Director revealed the facility's concern of the maneuvering space required to function within the Kitchen may be compromised by adding swing doors.	K 029		

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K 029	Continued From page 3 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/23/2012
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 4 furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K 072 The rope and slide bolt on room # 2 was removed on 11-12-2012 by the Dir. Of Maintenance. All other resident rooms doors were checked, and attachment rings were removed. New barrier ropes were purchased by the Administrator, and were installed by the Dir. Of maintenance.These barrier ropes are attached with easy releasing Velcro. The administrator educated the Dir. of Maintenance on acceptable door barriers on 11-15-2012. The nursing staff was educated as to what barrier ropes are acceptable, and that only the Maintenance Dept can install barrier ropes. This was done by the Dir. of Nursing and completed on 11-15-20`12 . Prior to installation of a barrier rope, the request is reviewed by the Dir. of Nursing. All barrier roped rooms, are noted on the facility " who has what list" which is reviewed bi-monthly by committee consisting of, Dir, of Nursing, Asst, Dir of nursing, Social services Dir, Administrator, Staff Development and Unit managers.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, eighteen (18) residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was eighty-six (86) on the day of the survey. The findings include: Observation, on 10/23/12 at 11:15 AM, with the Maintenance Director revealed the door opening to Resident Room 2 had a velvet rope barrier attached to the door jamb with a slide bolt spring snap. The slide bolt required dexterity with the use of the thumb to disengage the hook and release the rope barrier. Further observation, between 11:15 AM and 2:25 PM, with the Maintenance Director revealed provisions (attachment rings screwed into the door jamb) for attaching a rope barrier in the door openings for Resident Rooms 20, 23, 27, 28, 29, 38, 39, 41 and 54. Interview, on 10/23/12 at 11:15 AM, with the Maintenance Director revealed the velvet rope barrier installed on Resident Room 2, and			

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	185278	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW HEALTH AND REHABILITATION CENTER	9701 WHIPPS MILL RD. LOUISVILLE, KY 40223

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K 072	Continued From page 5 provisions on the additional door openings noted, were installed as directed by the Nursing Staff.	K 072		
	Reference: NFPA 101 (2000 Edition)			
K 147 SS=D	Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately thirty-five (35) residents, staff, and visitors. The facility has ninety-five (95) certified beds and the census was eighty-six (86) on the day of the survey. The findings include: Observation, on 10/23/12 at 3:20 PM, with the Maintenance Director revealed the hydrocollator (containing hot water) located within the Physical	K 147	K147 The outlet that the hydroculator was plugged into was changed to a GFI outlet. This was done on 11-12-2012 by the Dir. Of Maintenance. Outlets that are GFI protected were marked, and therapy staff was in serviced about what equipment must be plugged into a GFI protected outlet. This was done on 11-12-2012 by the Dir. Of maintenance. All other electrical equipment was checked and was plugged into appropriate outlets. This was completed on 11-12-2012 by the Dir. of Maintenance. The Dir. of Maintenance will check all the electrical equipment ocated in the therapy gym on a weekly basis, for 4 weeks and monthly thereafter to ensure it is plugged into appropriate outlet. This check has been added to facility Preventative maintenance program. The Preventative Maintenance program is reviewed monthly by the Regional Maintenance Manager andadministrator. CONT	11-12-1 11-13-2012

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K 147	Continued From page 6 Therapy Department, and not plugged into a ground fault circuit Interrupter (GFCI) outlet as required in wet areas. Interview, on 10/23/12 at 3:20 PM, with the Maintenance Director revealed he was not aware of the hydrocollator being plugged into a standard electrical outlet. Further interview, on 10/23/12 at 4:55 PM, with the Administrator and the Maintenance Director revealed the Staff currently working in the Physical Therapy Department had relocated the hydrocollator from its previous location where it was plugged into a GFCI outlet. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	MONTHLY PREVENATIVE MAINT. IS SUBMITTED AND REVIEWED BY QUALITY ASSURANCE COMMITTEE QUARTERLY ONGOING.	

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