

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

PRINTED 01/06/2016
FORM APPROVED
DMS NO 0938-0391

STATEMENT FOR THE STATE NUMBER OF DEFICIENCIES	PROVIDER AGENCY IDENTIFICATION NUMBER 185267	STATE OF RESIDENCE KENTUCKY	DATE SURVEY COMPLETED 12/17/2015
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NAME OF PROVIDER OF SERVICES CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON KY 40033
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4. PRIMARY STATEMENT OF DEFICIENCY F000 INITIAL COMMENTS	BY DATE	PROVIDER'S PLAN OF CORRECTION A CORRECTIVE PLAN IS REQUIRED TO BE SUBMITTED TO THE APPROPRIATE DEFICIENCY
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F000 INITIAL COMMENTS

A standard health survey was conducted on 12/15-17/15. Deficient practice was identified with the highest scope and severity at "E" level
F 282 483 20.k)(3)(i) SERVICES BY QUALIFIED PERSONS PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care

This REQUIREMENT is not met as evidenced by

Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for three (3) of fifteen (15) sampled residents (Resident #1, Resident #3 and Resident #10). A review of the comprehensive plan of care for Resident #1, Resident #3 and Resident #10 revealed staff would provide catheter care every shift. Interview revealed that catheter care included securing the catheter to the resident's thigh according to the facility policy. Observation of catheter care for Resident #1, Resident #3 and Resident #10 revealed the indwelling catheter was not secured to the resident's thigh according to the facility policy.

The findings include:

Review of the facility policy titled "Care Plan Interdisciplinary," dated 10/01/07 with a review date of 10/01/12 revealed the resident's care plan was updated and individualized to ensure

F000 The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth on the statement for deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and State Law.

1. Resident #1, #3, and #10 were immediately assessed and a foley catheter anchor/strap was immediately applied to the leg, to prevent movement or pulling of the foley catheter. The care plan was immediately updated to reflect that a foley catheter anchor is to be in place on Resident #1, #3, and #10. The SRNA kardex was immediately updated to reflect that a foley catheter strap/anchor is to be on resident #1, #3, #10 and to ensure placement with each foley catheter cleaning.
2. Given the nature of the deficiency it was deemed by the IDT that residents with foley catheters had the potential to be affected by the deficient practice. All residents with indwelling catheters have

DEFICIENCY IDENTIFICATION NUMBER: SUPPLIER REGISTRATION NUMBER

DATE

STATE

Jennifer Bartley RN LVA

1-26-16

A 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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STATEMENT OF DEFICIENCIES AND/OR CORRECTIVE ACTION	L1 PROVIDER SUPERVISOR ID OR LICENSE NUMBER 185267	L2 MULTIPLE CONTRIBUTION A. BUILDING _____ B. FLOOR _____	L3 DATE SURVIVOR COMPLETED 12/17/2015
NAME OF PROGRAM OR SUPERVISOR CEDARS OF LEBANON NURSING CENTER		STATE ADDRESS CITY STATE ZIP CODE 337 SOUTH HARRISON STREET LEBANON KY 40033	
4.4 DEFECTS	5.1 STATEMENT OF DEFICIENCIES (A FURTHER EXPLANATION MUST BE PRECEDED BY FULL AND COMPLETE AND CORRECTIVE ACTION INFORMATION)	6.1 FIELD TAG	7.1 PROVIDER'S PLAN OF CORRECTION (A CORRECTIVE ACTION SHOULD BE CORRESPONDENT TO THE APPROPRIATE DEFICIENCY)

F 262 Continued From page 3

F 262

Urinary catheter

Observation of catheter care for Resident #1 on 12/16/15 at 11:50 AM revealed the tubing for the urinary catheter was unsecured

3. Review of the medical record for Resident #10 revealed the facility admitted the resident on 10/23/07 with diagnoses including Chronic Kidney Disease, Kidney Failure, Urinary Retention, Obstructive and Reflux Uropathy, Rheumatoid Arthritis, Dementia, Hypothyroidism, and Heart Failure. Review of the Quarterly MOS dated 10/08/15 documented that the resident continued to require an indwelling catheter. Review of the Comprehensive Care Plan (revised 10/01/14) revealed intervention for care of the indwelling urinary catheter was for a stabilization device to be in place at all times.

Observation of Resident #10 at 9:35 AM on 12/17/15 revealed the catheter was attached to a bedside drainage bag. However, the tubing was not secured to the resident's leg as required by the facility's policy and the resident's Comprehensive Care Plan.

Interview with SRNA #6 at 9:35 AM on 12/17/15 revealed the catheter tubing was supposed to be secured to the resident's leg.

Interview with the Unit Coordinator on 12/17/15 at 2:15 PM revealed that she did rounds daily on the residents. She stated if the resident had an indwelling urinary catheter that it should be secured to their leg unless the physician orders it not to be secured. She further stated that when she did rounds she checked catheters to ensure they were secured and for cleanliness. She

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GRAFIC NUMBER, REFERENCE AND PLAN OF CONNECTION	PROVIDER/CLINIC/PLIER/CLIA IDENTIFICATION NUMBER: 185267	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SHEET COMPLETED 12/17/2015
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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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PRIMARY STATEMENT OF DEFICIENCIES AND CORRECTIVE ACTION SHOULD BE PROVIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID NUMBER PAGE	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY
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F 202 Continued From page 4

F 202

stated the SRNA should let the nurse know if a catheter was not secured. She stated the SRNAs looked at their Kardex for the resident to see if they have a catheter and if it is supposed to be secured but that it was ultimately the nurse's responsibility to ensure catheters were secured to the resident's thigh according to the policy.

Interview with the MOS Coordinator on 12/17/15 at 2:18 PM revealed the intervention for securing the urinary catheters should have been written on the care plan. She further revealed it was the administrator's responsibility to ensure the interventions for securing the urinary catheters were on the SRNA's care plan.

Interview with the Administrator on 12/17/15 at 2:30 PM revealed it was the policy of the facility to secure all urinary catheters. She further revealed it was the responsibility of all staff to ensure the urinary catheters were secured. The Administrator also stated if the care plan intervention was to provide catheter care, this included securing the urinary catheter.

F 315 483.25(d) NO CATHETER PREVENT UTI
SC=1 RESTORE BLADDER

F 315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

1. Resident #1 has a leg strap/anchor properly securing an indwelling catheter to prevent movement or pulling of the catheter and the device usage is noted in the plan of care and the SRNA kardex as directed by the plan of care.

FACILITY NAME (PLEASE PRINT) AND COMPLETE ADDRESS	PROVIDER / OPERATOR ORGANIZATION NUMBER 155077	PROVIDER IDENTIFICATION OR BUILDING NUMBER 15500	DATE SURVEY COMPLETED 12/17/2015
FACILITY TYPE (PLEASE PRINT) CEDARS OF LEBANON NURSING CENTER		STREET ADDRESS - CITY STATE ZIP CODE 337 SOUTH HARRISON STREET LEBANON KY 40033	
SUMMARY STATEMENT OF DEFICIENCY (ALL DEFICIENCIES MUST BE PREPARED BY FULL QUALITY OR QUALIFYING INFORMATION)	PROVIDER PLAN OF CORRECTION (DATE, RESPECTIVE TREATMENT PLAN OR CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE OF CORRECTIVE ACTION	DATE OF CORRECTIVE ACTION

F 315 Continued From page 5

I 315

This REQUIREMENT was not met as evidenced by

Based on observation, interview, record review and review of a facility policy, it was determined the facility failed to provide appropriate treatment and services to ensure urinary catheter tubing was secured to prevent possible injury/trauma of the urinary tract for three (3) of fifteen (15) sampled residents (Resident #1, Resident #3, and Resident #10). Observation of Resident #1, Resident #3, and Resident #10 revealed the indwelling urinary catheter tubing to be unsecured.

The findings include:

Review of a facility policy titled "Urinary Catheter Care" dated 10/01/07 with a review date of 10/01/12 revealed "To prevent the catheter from being pulled out, secure the catheter tubing to the thigh. BE VERY CAREFUL THAT NO TENSION IS PLACED ON THE CATHETER. Tension on the catheter will produce pain and will damage the meatus (insertion site)."

1. Review of the medical record for Resident #3 revealed the facility admitted the resident on 06/22/11 with a readmission date of 09/07/15 with diagnoses that include Chronic Kidney Disease, Urinary Retention, Peripheral Vascular Disease, Heart Failure, Parkinson's disease, and Major Depressive Disorder. Review of the resident's Quarterly Minimum Data Set (MDS) assessment dated 09/17/15 revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Further review of the MDS

1. Resident #3 has a leg strap/anchor properly securing an indwelling catheter to prevent movement or pulling of the catheter and the device usage is noted in the plan of care and the SRNA kardex as directed by the plan of care.

Resident #10 has a leg strap/anchor properly securing an indwelling catheter to prevent movement or pulling of the catheter and the device usage is noted in the plan of care and the SRNA kardex as directed by the plan of care.

2. Given the nature of the deficient practice, it was deemed by the IDT that residents with foley catheters had the potential to be affected by the deficient practice. All residents with indwelling catheters have anchors for foley catheters to properly secure and to prevent movement or pulling. All residents with catheters have a plan of care that is also reflected on the daily SRNA kardex, assuring the placement of foley catheter anchors to residents who require the device.

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PRINTED: 01/14/2016
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF GOALS, OBJECTIVES AND PLAN OF CORRECTION	PROVIDER(S) SUPPLIER/PCA IDENTIFICATION NUMBER 185267	MULTIPLE CONSTRUCTION - BUILDING _____ B/W/NO _____	PLAN OF CARE SURVEY COMPLETED 12/17/2015
FACILITY NAME (SIC CODE) AND ADDRESS CEDARS OF LEBANON NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 137 SOUTH HARRISON STREET LEBANON KY 40033	
L DEFICIENCY TAG	STATEMENT OF DEFICIENCIES WITH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFYING INFORMATION	D DEFICIENCY TAG	PROVIDER'S PLAN OF CORRECTION AND CORRECTIVE ACTION(S) MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 315 Continued From page 7

2. Review of the medical record revealed the facility admitted Resident #1 on 02/20/15 with diagnoses that included Retention of Urine Disorder of Kidney and Ureter Open wound of Buttocks Dementia and Hypertension Review of the Significant Change MOS Assessment dated 11/05/15 revealed Resident #1 required the use of an indwelling urinary catheter secondary to a diagnosis of Urinary Retention Review of the Comprehensive Care Plan for Resident #1 dated 04/02/15 revealed the facility addressed the use of an indwelling urinary catheter however no interventions for securing the urinary catheter were addressed Review of the SRNA care plan dated 02/20/15 revealed the SRNA was to provide catheter care and empty the bag however no interventions for securing the urinary catheter were addressed

Observation of catheter care for Resident #1 on 12/16/15 at 11:50 AM revealed the tubing for the urinary catheter was unsecured

3. Review of the medical record for Resident #10 revealed the facility admitted the resident on 10/23/07 with diagnoses including Chronic Kidney Disease Kidney Failure Urinary Retention Obstructive and Reflux Uropathy Rheumatoid Arthritis Dementia Hypothyroidism and Heart Failure Review of the Quarterly MOS dated 10/08/15 revealed Resident #10 required the use of an indwelling catheter for diagnoses of Urinary Retention and Kidney Failure Review of the Comprehensive Care Plan (revised 10/01/14) revealed the facility addressed the use of an indwelling urinary catheter with an intervention for care for the indwelling urinary catheter for a stabilization device in place at all times

F 315 The DON or designee will audit the Treatment Record for nurse compliance of tracking and assuring the plan of care is followed. This will be achieved by monitoring the TAR daily x1 week, then weekly x 4 weeks, then randomly one time a month x 3 months, then randomly each quarter with finding being reported to the QA committee for tracking and trending.
See attachment #4: treatment record audit.

The DON or designee will audit the resident plan of care and the SRNA kardex to ensure that each foley catheter has a plan of care in place and it is documented on the SRNA kardex. This will be achieved by monthly monitoring x 3 months the each quarter, with the finding being reported to the QA committee for tracking and trending.
See attachment #5 kardex/plan of care monitor.

1-18-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB NO. 0938-0331

STATE OF CONNECTICUT FACILITY CORRECTION	LICENSING NUMBER 185267	ADULT HOME CARE CENTER A BUILDING 6000	DATE SURVEY COMPLETED 12/17/2015
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NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS (SEE STATE ZIP CODE) 337 SOUTH HARRISON STREET LEBANON KY 40033
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STATE OF CONNECTICUT FACILITY CORRECTION	SUMMARY STATEMENT OF DEFICIENCIES A DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF DEFICIENCY INFORMATION	ID DEFICIT TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION MUST BE CLOSELY MONITORED TO THE APPROPRIATE DEFICIENCY	DATE COMPLETION
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F 315 Continued From page 8

F 315

Observation of Resident #10 at 9:35 AM on 12/17/15 revealed the catheter was attached to a bedside drainage bag. However, the tubing was not secured to the resident's thigh as required by the facility's policy and Comprehensive Care Plan.

Interview with SRNA #6 at 9:35 AM on 12/17/15 revealed the catheter tubing was supposed to be secured to the resident's leg. The SRNA further stated she thought the nurses were supposed to secure the urinary catheter to the resident's leg.

Interview with the Unit Coordinator on 12/17/15 at 2:15 PM revealed that she did rounds daily on the residents. She stated if the resident has an indwelling urinary catheter that it should be secured to their leg unless the physician orders it not to be secured. She further stated that when she did rounds she checked catheters to ensure they were secured and for cleanliness. She stated the SRNA should let the nurses know if a resident with a catheter does not have the catheter secured. She stated the SRNAs look at their Kardex for the resident to see if they have a catheter and if it is supposed to be secured, but that it is ultimately the nurse's responsibility to ensure catheters are secured to the resident.

Interview with the Director of Nursing (DON) on 12/17/15 at 2:10 PM revealed she did daily rounds to ensure urinary catheters were secured. She further revealed the SRNAs were supposed to notify the nurses if a urinary catheter was observed to be unsecured.

Interview with the Administrator on 12/17/15 at 2:20 PM revealed it was the policy of the facility to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER SUPPLEMENTAL IDENTIFICATION NUMBER 165207	LOCATION OF DEFICIENCY A. BUILDING _____ B. WING _____	DATE DEFICIENCY IS COMPLETED 12/17/2015
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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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DEFICIENCY STATEMENT OF DEFICIENCIES SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	DEFICIENCY CLASSIFICATION	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE LINKED TO THE APPROPRIATE DEFICIENCY
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<p>F 315 Continued From page 9</p> <p>secure all urinary catheters. She further revealed it was the responsibility of all staff to ensure the urinary catheters were secured</p>	F 315	<p>1. It is the policy of this facility to provide adequate supervision to minimize accidents. This is accomplished by locking the storage room doors, so that wandering residents will not have access to those room or any potentially hazard chemicals. The storage room doors were immediately locked.</p>
<p>F 323 483 25(h) FREE OF ACCIDENT HAZARDS SUPERVISION/DEVICES</p> <p>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</p>	F 323	<p>2. Given the nature of the deficiency, it was deemed by the IDT that all wandering residents had the potential to be affected by the deficient practice. Because all wandering resident are potentially affected the DON reviewed the plan of care and kardex to assure that a wandering plan of care was in place and interventions were appropriate and on the kardex for the SRNA to follow. In addition the Director of Maintenance had keys made immediately to the storage room doors to ensure compliance with locking the door</p>
<p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation, interview and facility policy review it was determined the facility failed to ensure the residents' environment remained free from accidents and hazards for four (4) unsampled residents that the facility had identified as "wandering residents." Observation on 12/17/15 revealed two (2) supply room doors were unlocked and contained medical supplies that could be hazardous to residents if ingested</p>		
<p>The findings include</p> <p>Review of the facility policy titled "Accident/Hazard Risk Assessment" with a reviewed date of 10/01/12 revealed all storage room doors should be locked at all times and not accessible to residents</p>		
<p>Observation of the supply room on Raley Hall on 12/17/15 at 9:45 AM revealed the door to be unlocked and the following medical supplies to be</p>		

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PRINTED 01/16/2016
FORM APPROVED
DMS NO 0938-0391

STATEMENT OF DEFICIENCIES DATE: 12/17/2015	X PROVIDER IDENTIFICATION NUMBER 185267	A. MULTIPLE PROVIDERS A. DRUGS B. SUPPLIES	DATE SURVEY CONDUCTED 12/17/2015
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NAME OF PROVIDER OR SUPPLIER

CFDARS OF LEBANON NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

437 SOUTH HARRISON STREET
LEBANON, KY 40033

F 403 PAGE 12 TAG	DEFICIENCY STATEMENT OF DEFICIENCIES DEFICIENCIES MUST BE PRECEDED BY THE REGULATORY IDENTIFYING INFORMATION	BY DATE TAG	PROVIDER PLAN OF CORRECTION STATEMENTS MUST BE PRECEDED BY DEFICIENCY IDENTIFYING INFORMATION DEFICIENCY	F 403 PAGE 12 TAG
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F 323 Continued From page 10

present and accessible to wandering residents
CaldaZinc Ointment Remedy Cleansing Body
Lotion Hydrogen Peroxide and Dimethicone
Skin Protectant Observation of the supply room
on Davis Hall on 12/17/15 at 10:00 AM revealed
the door to be unlocked and the following medical
supplies to be present and accessible to
wandering residents CaldaZinc Ointment and
Remedy Cleansing Body Lotion Review of the
Material Safety Data Sheets (MSDSs) on all
items revealed if swallowed to obtain medical
help or contact a Poison Control Center

Interview with the Maintenance Supervisor on
12/17/15 at 1:22 PM revealed the supply room
doors should be locked at all times He further
revealed he had 16 keys made to ensure staff
could have access to the supply room and keep
the doors locked at all times

Interview with State Registered Nurse Aide
(SRNA) #1 on 12/17/15 at 11:07 AM revealed the
majority of the time the supply room on Raley Hall
was unlocked

Interview with SRNA #2 on 12/17/15 at 11:10 AM
revealed the supply room doors were usually
locked

Interview with the Administrator on 12/17/15 at
10:45 AM revealed the supply room doors should
be locked at all times She further revealed when
she did rounds she was responsible to ensure
that all supply room doors were locked No
incidents had ever been reported regarding a
wandering resident entering the supply rooms

F 441 483.65 INFECTION CONTROL PREVENT
SS=E SPREAD LINENS

3. To enhance currently complaint
operations and under the direction of
the Maintenance Director, keyless door
entries and auto door closure were
installed on the storage room doors on
Raley and Davis Hall. The nursing staff
received an in-service regarding state
and federal requirements for minimizing
accidents and hazards situations on
01/12/2016. The training emphasizes
the importance of ensuring the safety of
the resident, by being complaint in
locking the storage door. The was
completed by the Maintenance Director.
Also the code for the keyless entry was
distributed. See attachment #6: in-
service regarding door locks.

4. A monitor was put in place by the
Maintenance Director to observe
compliance of locking the storage room
door. The Maintenance Director will
observe daily x 1 week, then weekly x 4
weeks, then randomly each quarter.
This will be reported to the QA
committee for tracking and trending any
discrepancies. See attachment #7

F 441

1-18-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIVE ACTION	PROVIDER IDENTIFICATION NUMBER 185267	MULTIPLE DEFICIENCY A BOLDING _____ DATE: _____	SURVEY COMPLETED 12/17/2015
NAME OF PROVIDER OR NUMBER CEDARS OF LEBANON NURSING CENTER		STREET ADDRESS (IFY APPLICABLE) 317 SOUTH HARRISON STREET LEBANON, KY 40033	
NCLF CODE	PRIMARY STATEMENT OF DEFICIENCY (THE STATEMENT SHOULD BE PREPARED BY FULL-SCHEMATICALLY OR RESIDENT IDENTIFYING INFORMATION)	N/A PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 441	<p>Continued From page 11</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it:</p> <ol style="list-style-type: none"> (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. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<ol style="list-style-type: none"> 1. It is the policy of this facility to provide an adequate infection control program, in essence to serving food trays without touching the food, and to wear gloves when obtaining a blood sugar. In this case after the survey reported that food was touched by the SRNA during serving of the tray. The SRNA were reminded and educated to maintain infection control by not touching the food when serving. Also in this case after the survey reported that gloves were not used when obtaining a blood glucose, the LPN was educated on the proper technique of wearing gloves. 2. Given the nature of the deficient practice it was deemed by the IDT that all residents had the potential to be affected by the deficient practice of touching the food while serving the trays. The DON reviewed the practice of tray serving with education being provided immediately to anyone observed touching the resident's food. This was completed by the Director of Nursing by watching the next 6 meal passes, including trays being served in the rooms to ensure that SRNA were serving the food properly without food being touched without gloves. No other residents were affected. Given the nature of the deficiency

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NAME OF PROVIDER/CLIA IDENTIFICATION NUMBER	PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER	CLIA IDENTIFICATION NUMBER	AS DATE SERVICE COMPLETED
	185287		12/17/2015

NAME OF PROVIDER/CLIA IDENTIFICATION NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF LEBANON NURSING CENTER	337 SOUTH HARRISON STREET LEBANON KY 40033

4-STATE	ICD-9-CM	PROVIDER'S PLAN OF CORRECTION
06	00	EACH CORRECTIVE ACTION SHOULD BE REPORTED SEPARATELY TO THE APPROPRIATE AGENCY.

F 441 Continued From page 12

This STANDARD is not met as evidenced by Based on observation, interview and facility policy review, the facility failed to maintain an effective infection control program to prevent the development and transmission of disease/infection for 12 (twelve) unsampled residents. Observations in the main dining room and the Raley Hall on 12/15/15, 12/16/15, and 12/17/15 during the lunch meal service and the dinner meal service revealed staff touched residents' foods with bare hands. Furthermore, observation on 12/15/15 at 3:44 PM revealed staff checked a resident's blood sugar without wearing gloves.

The findings include:

Review of the facility Dining Room-Meals policy dated 03/11/15 revealed residents would be served meals that were nutritious and served in a manner consistent with accepted standards of care. The policy further noted sanitary conditions and safety would be maintained for all residents.

1. During the dinner meal on 12/15/15 at 5:25 PM in the Raley Hall of the facility, SRNA #7 was observed to remove an unsampled resident's biscuit from the plastic package on the resident's tray with her bare hands and place it on the resident's tray. Further observation revealed SRNA #7 removing the biscuit from the packaging of two other unsampled residents with her bare hands and place it on their trays.

During the lunch meal on 12/16/15 at 11:30 AM in the main dining room of the facility, SRNA #7

F 441 IDT that all Residents had the potential to be affected by the deficient practice of obtaining blood sugars without gloves. The DON reviewed the practice of obtaining blood sugars with the nursing staff, with education being provided to the nursing staff. The Director of Nursing watched 3 nurses' complete 3 blood sugars each to ensure that the deficient practice was corrected. The deficient practice did not occur. No other residents were affected.

3. To enhance currently complaint operations and under the direction of the DON on 01/12/2016, all nursing staff received an in-service regarding food handling and proper ways to serve trays with emphasis on handling of bread, and finger foods. See attachment #8.

To enhance currently compliant operation and under the direction of the DON on 01/12/2016, all nursing staff received an in-service regarding obtaining blood sugars with emphasis placed on when to wear gloves and cleaning the machine. See attachment #9. Attachment #10: monitor compliance in obtaining blood sugars.

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PRINTED: 01/06/2016
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OMB NO 0938-0391

NUMBER OF DEFICIENCY AND PLAN OF CORRECTION	ALL PROVIDER/SUPPLIER/CLIA CERTIFICATION NUMBER 167207	(X2) MULTIPLE CORRECTIVE ACTION TAGS A. BULKING _____ B. ZONE _____	DATE PLAN OF CORRECTION COMPLETED 12/17/2015
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NAME OF PROVIDER/SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON KY 40033
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DEFIC TAG	CORRECTIVE ACTION TAGS EACH DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF ALL CORRECTIVE ACTION INFORMATION	DEFIC TAG	PROVIDER/PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	DEFIC TAG DATE
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F 441 Continued From page 13

was observed to remove an unsampled resident's bread from the plastic package on the resident's tray with her bare hands and place it on top of the package. Continued observation of the lunch meal revealed SRNA #7 removed the brownie and the bread from the plastic packaging of another unsampled resident's tray with her bare hands and placed it on top of the packaging for the resident to eat. Further observations of the lunch meal in the main dining room on 12/16/15 revealed Licensed Practical Nurse (LPN) #3 was observed to remove an unsampled resident's bread from the plastic package on the resident's tray with her bare hands and place it on top of the package. State Registered Nurse Aide (SRNA) #6 was observed to remove the brownie and the bread from the plastic packaging of another unsampled resident's tray with her bare hands and place it on top of the packaging for the resident to eat. Observation of the lunch meal in the Raley Hall of the facility on 12/16/15 at 11:58 AM revealed SRNA #1 removed the brownie and bread from the plastic packaging with her bare hands for four unsampled residents and placed the items on their trays. Further observation revealed SRNA #1 removed a pimento cheese sandwich and crackers from the plastic package with her bare hands and placed it on the unsampled resident's tray.

Interview with SRNA #6 on 12/16/15 at 1:45 PM revealed she had been trained to perform hand washing before beginning meal service and to use hand sanitizer between trays. The CNA stated she should not have touched the resident's bread with her bare hands and should have used gloves to handle the food.

Interview conducted on 12/17/15 at 1:20 PM with

F441

4. A quality assurance program was implemented under the supervision of the DON or designee to monitor the serving of food trays. The DON or designee will observe 2 meals daily x 1 week, then 2 meals weekly x 4 weeks, then 2 meals monthly x 3 months, then 2 meals quarterly, with the results being reported to the QA committee for tracking and trending. See attachment #11 tray service audit.

A quality assurance program was implemented under the supervision of the DON to monitor blood sugars. The DON or designee will observe 3 nurses complete 3 blood sugar each daily x 1 week, then the DON will observe 3 nurses complete 3 blood sugars weekly x 4 weeks, then the DON will observe 3 nurses complete 3 blood sugars monthly x 3 months then the DON will observe 3 nurses complete 3 blood sugars every quarter, with the findings being reported to the QA committee for tracking and trending. See attachment #10, blood sugar monitor.

1-18-16

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

PRINTED 01/06/2016
FORM APPROVED
OMB NO 0938-0391

FACILITY NAME AND ADDRESS CEDARS OF LEBANON NURSING CENTER	PROVIDER IDENTIFICATION NUMBER 185267	FACILITY TYPE NURSING HOME	SURVEY DATE 12/17/2015
FACILITY PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER		STREET ADDRESS (DO NOT LEAVE BLANK) 117 SOUTH HARRISON STREET LEBANON, KY 40033	
STATE	SUMMARY STATEMENT OF DEFICIENCY AND DEFICIENCY ACTION PREPARED BY FULL REGULATORY OR COMPLIANCE OFFICIAL	ICD PREFIX TAG	FACILITY PLAN OF CORRECTION HEAD OF DEFECTIVE ACTION GROUP IN PROGRESS TO TREAT DEFICIENCY

F 441 Continued From page 14

F 441

LPN #3 revealed the bread usually comes in the plastic packaging and staff was trained to try to remove it without touching the bread. The LPN stated she had been trained to keep her hands clean and sanitized during meal service however she stated she had not received any training regarding using gloves during tray setup.

Interview with SRNA #1 on 12/16/15 at 1:30 PM revealed she was not trained to wear gloves when handling residents' food. She stated she was trained to wash her hands before meal service begins and to use hand sanitizer between trays. She further stated that she should have worn gloves when handling food items.

Interview with SRNA #7 on 12/16/15 at 1:50 PM revealed she was not trained to wear gloves when handling the residents' food. She stated she was trained to use hand sanitizer before handling the residents' food. She further stated she did not feel she should have worn gloves since she used hand sanitizer and was not trained to wear gloves.

Interview with the Administrator on 12/16/15 at 4:05 PM revealed that nursing staff was trained to use aseptic technique when handling the residents' food. She stated they were trained to wash their hands prior to meal service and use hand sanitizer between trays or before touching utensils. She further stated the facility does not train staff to wear gloves when touching resident food but they were trained to touch food as minimally as possible and they should not be reaching into the packaging and pulling the food out with their bare hands.

2. Review of the facility's policy titled "Blood

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1. PROVIDER NAME AND CONTACT INFORMATION CEDARS OF LEBANON NURSING CENTER	2. PROVIDER IDENTIFICATION NUMBER 185267	3. MEDICARE CONTRACT ID NUMBER 4. BILLING 5. WING	6. SERVICE PERIOD COMPLETED 12/17/2015
7. NDA OR PROVIDER SUPPLIER CEDARS OF LEBANON NURSING CENTER		8. STREET ADDRESS CITY STATE ZIP CODE 337 SOUTH HARRISON STREET LEBANON KY 40033	
9. AGENCY STATEMENT OF DEFICIENCIES IDENTIFIED MUST BE PRECEDED BY FULL REGULATORY JURISDICTION IDENTIFYING INFORMATION		10. AGENCY TAG	11. PROVIDER PLAN OF CORRECTION 12. REFERRED TO AS A FINISH DATE 13. CROSS REFERENCED TO THE APPROPRIATE CERTIFICATE
F 441 Continued From page 15 Glucose Monitoring and Sliding Scale Insulin " with a revised date of 09/23/08 revealed instructions on how to monitor a resident's blood glucose. However, the policy did not address the use of gloves while performing blood glucose monitoring on a resident. Observation of blood glucose monitoring for Resident A on 12/15/15 at 3:44 PM revealed LPN #2 performed the blood glucose monitoring test without wearing gloves. Interview with LPN #2 on 12/15/15 at 4:10 PM revealed gloves were supposed to be worn at all times when performing blood glucose tests on residents. He stated he was very nervous being observed and forgot to put the gloves on. Interview with the Director of Nursing (DON) on 12/15/15 at 4:35 PM revealed nurses were trained to wear gloves when performing a blood glucose test on residents. She further revealed she monitored the nurses regularly to ensure that infection control practices were being followed. The DON also revealed the facility did not have a policy stating that staff had to wear gloves while performing a blood glucose test.		F 441	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2016
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/17/15 as alleged.	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

859 246 2307

Office Inspector General

02:21:19 p.m. 01-06-2016

4/44

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

PRINTED: 01/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER		STREET ADDRESS CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
(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)

K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 edition)

Facility type: SNF/NF

Type of structure: Type V (000)

Smoke Compartment: Three (3)

Fire Alarm: Full fire alarm (upgrade completed in 2009)

Sprinkler System: Full sprinkler system

Generator: Type II Diesel installed 1995

A Standard Life Safety Code Survey was conducted on 12/16/2015. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was fifty-six (56). The facility was licensed for sixty (60) beds.

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 deficiency identified at an "F" level.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 144

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1.

To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.

Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

2-11-16

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.

859 246 2307

Office Inspector General

02:21:50 p.m. 01-06-2016

5/44

PRINTED: 01/06/2016
FORM APPROVED
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: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 144 ; Continued From page 1

K 144

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, sixty (60) residents, staff and visitors.

The findings included:

Record review of the monthly emergency generator testing records on 12/16/15 at 3:30 PM, with the Maintenance Director, revealed the emergency generator has been exercised monthly for fifteen (15) minutes instead of the required minimum of thirty (30) minutes during the months of July, August, September and October 2015. Interview with the Maintenance Director, revealed the emergency generator was set on an automatic timer and he was not aware that the timer was set for a run-time of fifteen (15) minutes instead of the required thirty (30) minutes.

The findings were acknowledged by the Administrator during the exit conference.

NFPA 110 (1999 Edition)

K 144

It is the policy of Boyd Nursing and Rehabilitation Center to maintain life and safety compliance according to the National Fire Protection Association Standards. On 12/16/15 the Maintenance Director reset the emergency generator automatic timer for a run-time of thirty minutes (30) as required by the National Fire Protection Association standards. The Regional Maintenance Supervisor educated the facility Maintenance Director on 2/17/15 on the proper procedure of completing generator monthly testing under the required minimum thirty minute (30) timeframe and properly recorded.

859 246 2307

Office Inspector General

02:22:17 p.m. 01-06-2016

6/44

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
(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)

K 144 : Continued From page 2

K 144

6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.

Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.

6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of thirty (30) minutes, using one of the following methods:

(a) Under operating temperature conditions or at not less than thirty (30) percent of the EPS nameplate rating

(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer

The date and time of day for required testing shall be decided by the owner, based on facility operations.

The Administrator will audit the generator testing records each month to assure the thirty minute (30) required testing time is exercised. Any discrepancies of these records will be taken to the monthly facility Safety Committee (members include Administrator, Director of Nursing Services, Medical Records, Payroll Clerk, Dietary Manager, Infection Control Coordinator, Activities Director and Maintenance Director) and forwarded to the Regional Maintenance Director for review and recommendations for improvement to meet required standards.

Completed 12/17/15