

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023
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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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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 05/13/14 through 05/16/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of "E".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Countryside Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." <u>F225</u> Nurse Aide Abuse Registry Checks (NAAR) were completed on Certified Nurse Aide #1 and Licensed Practical Nurse #1 on 5/15/14 by Assistant Director of Nursing with no findings entered. NAAR was completed on current employees by Assistant Director of Nursing on 5/15/14 with no findings entered.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Cagle</i>	TITLE <i>Administrator</i>	(X6) DATE 6/9/14
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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 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the Nurse Aide Abuse Registry (NAAR) checks were completed, prior to hiring a staff member, for two of three staff (Certified Nurse Aide #1 and Licensed Practical Nurse (LPN) #1).</p> <p>The findings include:</p> <p>Review of the facility policy "Abuse Prohibition", dated 11/27/13, revealed the center will screen potential employees for a history of abuse, neglect, or mistreating patients, including checking with the appropriate licensing boards and registries and the center will not employ individuals who had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of others, or misappropriation of property.</p> <p>1. Review of CNA #1's Personnel Record revealed the employee's hire date was 04/14/14 and there was no evidence a Nurse Aide Abuse Registry check had been completed.</p> <p>2. Review of LPN #1's Personnel Record revealed the employee's hire date was 01/21/14 and there was no evidence a Nurse Aide Abuse</p>	F 225	<p>Administrator, Director of Nursing, Assistant Director of Nursing and Benefits Coordinator were re-educated by the Manager of Clinical Operations on F225, to include screening employees through the State NAAR on 5/16/14.</p> <p>Administrator and Director of Nursing will review new hire employee files for three months prior to hire. Corrective action and/or re-education will be provided at point of discovery. Administrator will report findings to the Performance Improvement Committee for further recommendations.</p> <p>Completion Date</p>	6/2/14	

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F 225	Continued From page 2 Registry check had been completed. Interview with the Director of Nursing (DON), on 05/16/14 at 8:45 AM, revealed the corporate office audits all potential new hires for these areas and informed the facility, if an employee was eligible for hire. However, the facility had no record Nurse Aide Abuse Registry checks had been completed for these two (2) staff. Interview with the Administrator, on 05/16/14 at 9:15 AM, revealed the NAAR checks had only been done this way for the last three (3) months and there had only been four (4) employees hired, but this would be corrected.	F 225			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care for one (1) of thirteen (13) sampled residents (Resident #1), in a manner and in an environment that maintains and enhances a resident's dignity and respect by ensuring a dignity bag cover was on Resident #1's urinary catheter during transport throughout the facility. The findings include:	F 241	<u>F241</u> Resident #1 was interviewed by Social Service Director on 5/16/14 to evaluate any psychosocial needs not addressed and she had no concerns with care. Certified Nurse Aide #2 and Rehab department was re-educated by the Director of Nursing and Assistant Director of Nursing regarding providing care in a manner to enhance or maintain a resident's dignity and respect to include keeping urinary catheter bags covered on 6/02/14.		

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F 241	<p>Continued From page 3</p> <p>Record review revealed the facility admitted Resident #1 on 4/29/14 with diagnoses which included Hypertension, severe Chronic Obstructive Pulmonary Disease (COPD), and a history of Hypertonic Bladder.</p> <p>Review of the admissions Minimum Data Set (MDS) assessment, dated 5/8/14 revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief interview for Mental Status (BIMS) score of eleven (11).</p> <p>Observation of Resident #1 on 5/14/14 at 1:35 PM, revealed Resident #1's was sitting in Occupational Therapy with a urinary catheter bag with no dignity bag cover under the resident's wheelchair.</p> <p>Further observation of Resident #1, on 5/15/14 at 12:50 PM, revealed the resident was wheeled in his/her wheelchair to the Therapy Department with the urinary catheter bag under the resident's wheelchair without a dignity bag cover.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 5/15/14 at 1:30 PM, revealed the facility uses a dignity bag to cover urinary catheters when residents were transported in the hallway and when catheter bags were placed on the side of the bed, visible to the door/hallway.</p> <p>Interview with the Director of Nursing Services (DON) and the Administrator, on 5/16/14 at 9:15 AM, revealed residents with urinary catheters should have a dignity bag.</p>	F 241	<p>Privacy bag was placed on resident #1 by nurse aide #1 on 5/15/14.</p> <p>Social Services conducted interviews of current residents regarding care with BIMS greater than eight on 5/21/14, none of the residents interviewed voiced care or dignity concerns.</p> <p>Current residents with catheters were reviewed by Director of Nursing on 5/16/14 with no concerns noted.</p> <p>Re-education was provided to the nursing staff, rehab staff, and recreation staff by Assistant Director of Nursing regarding providing care in a manner to enhance or maintain a resident's dignity and respect to include keeping urinary catheter bags covered, and ensure consistency of privacy during transport throughout the facility on 6/02/14.</p> <p>Unit Managers/Charge nurse will make random observation rounds each shift daily for one week, then three times per week, for three weeks and as determined by the monthly Performance Improvement Committee with corrective action at the time of discovery to ensure catheter bags are covered.</p>		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	Director of Nursing and Social Service Director will interview five		

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F 431	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure it was determined the facility failed to ensure narcotics</p>	F 431	<p>residents/visitors/family members per week for 30 days for concerns of dignity and respect and review of catheter bag cover in place during transport, then three per week for 60 days. Corrective action and/or re-education will be provided at point of discovery. Director of Nursing will report findings to the Performance Improvement Committee for further recommendations.</p> <p>Completion Date 6/2/14</p> <p><u>F431</u></p> <p>The Maintenance Director installed a side to side lock to the outside of the medication refrigerator (one of one) in the medication room on 5/16/14.</p> <p>The Director of Nursing reviewed three of three medication carts to ensure the double lock narcotic system is in place and operational, no concerns noted on 5/16/14.</p> <p>Assistant Director of Nursing re-educated licensed nurses and certified medication aides on F431 storage of drugs; providing double locked compartments for Scheduled II narcotics on 6/02/14.</p>		

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F 431	<p>Continued From page 5</p> <p>were stored under double lock and key in the facility's one (1) of one (1) medication room refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Management of Controlled Drugs", dated 5/15/14, revealed all controlled drugs are stored under double lock, sperate from other medications.</p> <p>On 05/16/14 at 8:25 AM, an observation was made in the presence of the Director of Nursing (DON) of the locked medication room. Inside the medication room was a medication refrigerator that was not locked. The refrigerator contained one (1) Ativan 2 milligram (mg) vial. Interview with the DON at the time revealed the pharmacy was responsible for stocking Ativan in the Emergency Drug Kit (EDK) in the medication room refrigerator.</p> <p>On 05/16/14 at 10:15 AM, interview with the Unit Manager revealed the Ativan 2 mg vial was stored in the Medication Room refrigerator. She stated there should have been a lock on the refrigerator to secure the controlled medication. She revealed the Ativan in the EDK was counted each shift as being in the refrigerator and logged into the controlled drug book.</p> <p>On 05/16/14 at 10:21 AM, interview with Assistant Director of Nursing revealed the Ativan 2 mg stored in the medication room refrigerator should have been under double lock to ensure the security of the medication.</p> <p>On 05/16/14 at 11:48 AM, interview with Administrator revealed she was under the</p>	F 431	<p>Director of Nursing and Assistant Director of Nursing will review storage of Scheduled II drugs three times per week for four weeks then weekly for two months. Corrective action and/or re-education will be provided at point of discovery. Director of Nursing will report findings to Performance Improvement Committee for further recommendations.</p> <p>Completion Date</p>	6/2/14

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F 431	Continued From page 6 assumption that the plastic seal on the EDK in the Medication Room Refrigerator was considered to be the second lock for controlled medications. She stated a lock box would be placed in the refrigerator to secure this medication.	F 431			

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K.000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1993, with 25 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1993.</p> <p>GENERATOR: Type-II generator installed in 1993. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/14/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Fifty-Three (53) beds with a census of Fifty (50) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K.000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Countryside Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>D. Sharon Cagle</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/9/14</i>
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K 144 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty-three (53) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>Generator documentation review, on 05/14/14 at 2:17 PM with the Maintenance Supervisor, revealed the generator did not have documentation on the amount of load the facility was pulling from the generator on a monthly basis. Further review determined the facility did not have an annual load bank test performed on the generator during the year of 2013.</p>	K 144 <u>K144</u>	<p>A low bank test was performed on the generator by VanGuard Generator Services on 5/27/14. The generator was inspected and exercised per NFPA 110 requirements with no areas of concern.</p> <p>The generator will continue to be inspected weekly and exercised under load for 30 minutes monthly per NFPA 99 and documented in TELS by the Maintenance Director.</p> <p>The Maintenance Director was re-educated by the Administrator on NFPA 99 and NFPA 110 monthly load test requirements with required documentation on 6/02/14.</p> <p>Administrator will review TELS monthly for documentation of inspection of generator under load, and annual load bank test if required per NFPA code, monthly for one year. Corrective action and/or re-education will be provided at point of discovery. The Administrator will report findings to the Performance Improvement Committee monthly.</p> <p>Completion Date</p>	6/2/14

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K 144	Continued From page 2 Interview, on 05/14/14 at 2:18 PM with the Maintenance Supervisor, revealed the facility has the annual load bank test in the contract from the generator contractor but was unaware the testing was not completed as required. The census of fifty (50) was verified by the Administrator on 05/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/14/14. Actual NFPA Standard: Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 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.	K 144		

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K 144	Continued From page 3 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144			