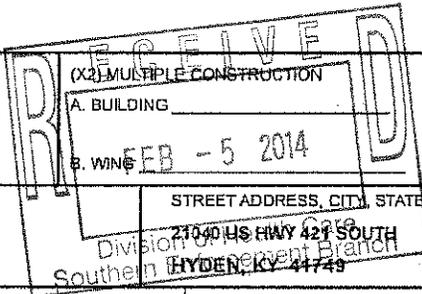


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ FEB - 5 2014 | (X3) DATE SURVEY COMPLETED 01/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2100 US HWY 427 SOUTH HYDEN, KY 41749 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 160 SS=B | <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure funds were conveyed to the individual administering the resident's estate within thirty (30) days of the resident's death for five (5) of five (5) residents who had expired and whose records were selected for review (Residents A, B, C, D, and E).</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Resident Funds Policy and Procedures," undated, on 01/10/14, at 3:15 PM, revealed upon the death of a resident with funds deposited in the facility, the facility would, within 30 days of the resident's death, convey the detail of the resident's funds and a final accounting to the individual or probate jurisdiction administering the resident's estate.</p> <p>1. Review of Resident A's personal care fund</p> | F 160 | <p>F - 160</p> <ol style="list-style-type: none"> The Escrow Accounts of Residents A, B, C, D, and E have now been closed and all funds have been conveyed. All Escrow Accounts have been reviewed by Administrator to ensure that any personal care fund of a deceased resident had the funds conveyed within 30 days of the resident's death. All deceased residents have had funds conveyed from the personal fund account. An in-service was conducted with the Admissions Coordinator / Escrow Staff by the Administrator on January 10, 2014 regarding the facility policy / protocol for Escrow Accounts. The in-service also included in-service education | 2/7/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Melissa L. Sparks

TITLE
Administrator

(X6) DATE
2/5/14

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 160 | Continued From page 1 record on 01/10/14, at 2:55 PM, revealed the resident expired on 10/30/13; however, the final conveyance of funds in the amount of \$1,281.00 was not completed until 01/08/14, 40 days past the 30-day timeframe. 2. Review of Resident B's personal care fund record on 01/10/14, at 3:00 PM, revealed the resident expired on 11/02/13; however, the final conveyance of funds in the amount of \$93.00 was not completed until 01/08/14, 37 days past the 30-day timeframe. 3. Review of Resident C's personal care fund record on 01/10/14, at 3:05 PM, revealed the resident expired on 11/08/13; however, the final conveyance of funds in the amount of \$1,624.11 was not completed until 12/10/13, two days past the 30-day timeframe. 4. Review of Resident D's personal care fund record on 01/10/14, at 3:10 PM, revealed the resident expired on 11/30/13; however, the final conveyance of funds in the amount of \$938.00 was not completed until 01/08/14, nine days past the 30-day timeframe. 5. Review of Resident E's personal care fund record on 01/10/14, at 3:12 PM, revealed the resident expired on 07/06/13; however, the final conveyance of funds in the amount of \$1,281.00 was not completed until 01/08/14, 40 days past the 30-day timeframe. Interview conducted with the Administrator on 01/10/14, at 3:30 PM, revealed the funds from the deceased resident accounts should be conveyed within 30 days of the resident's death. The Administrator stated she thought the facility might | F 160 | F-160 Produced by The Office of Long Term Care titled "Resident Trust Funds." The Administrator also reviewed the in-service education material. 4. A CQI designee will review all resident personal fund accounts weekly for one month to ensure that all funds of an expired resident are conveyed within 30 days. After one month, the accounts will be reviewed by the CQI designee monthly for three months. Any deficient practice will be corrected immediately and reported to the CQI committee for further follow up and review. 5. Date of Completion : February 7, 2014 | 2/7/14 | |

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| F 160 | Continued From page 2 have a couple of accounts that had been closed late, but had not been aware there were five late. The Administrator stated the Admissions Coordinator was responsible for closing deceased resident accounts, and stated the Admissions Coordinator should have been aware it was her responsibility to close the residents' accounts within 30 days. Interview conducted with the Admissions Coordinator on 01/10/14, at 3:22 PM, confirmed the resident funds had not been conveyed within the 30-day timeframe for Residents A, B, C, D, and E. The Admissions Coordinator stated she was aware the accounts were to be closed within 30 days after the resident expired, but stated she was not aware she was responsible for closing the accounts. | F 160 | | |
| F 248 SS=E | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's activity calendars, it was determined the facility failed to provide an ongoing program of activities designed to meet the interests and physical, mental, and psychosocial wellbeing of each resident. The facility failed to schedule and/or provide activities on Thursdays or Saturdays during the months of October 2013, | F 248 | <u>F-248</u> 1. The Activity Calendar has been revised to include activities on Thursdays and also continue the beauty shop and bookmobile services. Saturday Activities have also been revised to include additional activities on that day. Residents have been interviewed by the Activities Director to determine preferred activities. The Restorative Aide or other designated personnel, in the absence of the restorative aide, will ensure weekend activities are conducted. The Activity Director will review with nursing supervisors on Friday the plan for the weekend | 2/7/14 |

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| F 248 | <p>Continued From page 3 November 2013, December 2013, and January 2014.</p> <p>The findings include:</p> <p>Interview with the facility's Nurse Consultant on 01/10/14 at 3:45 PM revealed the facility did not have a policy related to activities provided by the facility. According to the Nurse Consultant, the facility expected activities to be provided on a daily basis and the Activities Director to provide a monthly calendar of scheduled activities to the residents at the facility. In addition, the Nurse Consultant stated the Activities Director was also to ensure an activities calendar was posted on the wall in the hallways of the facility. The Nurse Consultant stated the activities were to be announced daily over the intercom and Certified Nursing Assistants (CNAs) and other staff were to provide assistance to residents to and from the activities. The Nurse Consultant also stated the Restorative Aide assisted with activities on the weekends.</p> <p>A review of the Activity Calendars for October 2013, November 2013, December 2013, and January 2014 revealed the facility had scheduled two activities, "beauty shop" and "book mobile," on every Thursday of the months. In addition, a review of the Activity Calendars revealed the facility identified visits with "Friends and Family" as the activities on Saturdays, at 2:00 PM, for the months of October 2013, November 2013, December 2013, and January 2014.</p> <p>A review of the Resident Council Meeting minutes for October 2013 revealed residents reported the facility often scheduled the Restorative Aide to provide activities to the residents on the</p> | F 248 | <p><u>F- 248</u> activities to ensure residents will have on going meaningful activities program</p> <p>2. All interviewable residents have been interviewed by the Activities Director to determine preferred activities of the residents and include them on the monthly activity calendar. Activities will be conducted on the weekends as scheduled. The activity calendar has been revised to include additional activities on Thursdays and Saturdays.</p> <p>3. An In-service was conducted on January 10, 2014 with the Activities Director by the Administrator regarding the regulations related to</p> | 2/7/14 | |

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| F 248 | <p>Continued From page 4</p> <p>weekends, but the facility occasionally "pulled" the Restorative Aide to work the nursing units on weekends and, as a result, activities were not provided.</p> <p>Interviews with seven alert and oriented residents in a group meeting held on 01/09/14 at 9:30 AM revealed the activities were "very lacking" and the male residents at the facility did not enjoy "beauty shop" as an activity. The residents said, "The beauty shop and the book mobile were good services the facility provided but not good activities." The residents stated, "If we did not have family or friends visiting on the weekends, it was very boring at the facility."</p> <p>Observation of the activity scheduled for 10:30 AM on 01/10/14 revealed three people singing gospel music, accompanied by a piano player, in the Dining Room. Although seven residents were observed to be present during the activity, three of the residents were observed to have their eyes closed as if they were asleep. The Activities Director was not present for the activity during the observation.</p> <p>Interview with Certified Nurse Aide (CNA) #2 on 01/10/14 at 10:40 AM, and CNA #3 on 01/10/14 at 10:45 AM revealed the facility routinely announced activities over the intercom to let residents and staff know when activities were to begin and they assisted residents to the activities. At the time of the interviews on 01/10/14, the CNAs stated the residents that they had been assigned to assist with care on 01/10/14 did not want to attend activities and preferred to "stay in bed."</p> <p>Interview with the Activities Director on 01/10/14</p> | F 248 | <p>F-248</p> <p>the ongoing activity program of the facility. Educational material included the need for the activities scheduled to meet the comprehensive assessment, the interests, and the physical, mental and psychosocial well being of the residents. The Activity Director has also met with the resident council to discuss their interests and input and will continue to address activities in each monthly meeting. Additional games and supplies have been purchased to better meet the requests of the residents.</p> <p>4. A designee of the CQI committee will review the activity calendar and make direct observations</p> | 2/7/14 | |

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| F 248 | <p>Continued From page 5</p> <p>at 11:30 AM revealed he worked from 8:00 AM until 5:00 PM Monday through Fridays at the facility. The Activities Director stated he did not attend all of the activity on 01/10/14 at 10:30 AM because he had been asked by the administrative staff to leave the facility to obtain food for the facility staff. The Activities Director stated several of the residents had not wanted to attend the activity offered on 01/10/14 at 10:30 AM, and stated, "it was a stay-in-the-bed kind of day." The Activities Director stated the Restorative Aide was in charge of the activities on the weekends and was to offer the residents a choice of activities. The Activities Director said the Administrator approved the Activity Calendar each month and acknowledged "beauty shop" and "book mobile" were listed as activities on the schedule. The Activities Director acknowledged residents paid for the services they received at the "beauty shop" and stated not all of the residents, including male residents, received services from the beauty shop. In addition, the Activities Director acknowledged the "book mobile" was provided by an outside public service and that not all residents utilized the services of the "book mobile." The Activities Director acknowledged the facility offered visits by family and friends as an activity on Saturdays, at 2:00 PM, and acknowledged the facility offered no other activity to residents that did not receive visits by friends and/or family on the weekends.</p> <p>Interview with the Administrator on 01/10/14 at 3:45 PM revealed she reviewed and approved the Activity Calendar every month and was unaware of the residents' concerns with activities. The Administrator said CNAs were to assist residents to and from activities and was unaware of the low attendance to the activity on 01/10/14 at 10:30</p> | F 248 | <p>F- 248</p> <p>of the activities offered by the facility on a weekly basis to assure that activities are conducted as scheduled and that a variety of activities are offered on each day of the week. The designee will conduct random interviews with residents to ensure activities are being provided throughout the week and on the weekends. The designee will also observe activities for resident participation and interview them if the activity was enjoyable for them. The designee will review the activities weekly for one month and then monthly for 3 month. Any irregularity noted will be corrected immediately and referred</p> | 2/7/14 | |

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| F 248 | Continued From page 6 AM or that residents had their eyes closed, as if asleep, during the activity. The Administrator acknowledged the Activities Director had been asked to leave the facility to obtain food for facility staff on 01/10/14 during the scheduled activity and, as a result, was not present for all of the activity. | F 248 | to the CQI committee for further review. | | |
| 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 a review of the Minimum Data Set (MDS) reference manual, the facility failed to ensure a comprehensive assessment had been completed within fourteen (14) days after a significant change in status that would not normally resolve on its own for two of seventeen (17) sampled residents (Residents #6 and #12). The facility failed to conduct a significant change in resident status assessment when Residents #6 and #12 | F 274 | 5. Date of Completion: February 7, 2014 | 2/7/14 | |

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| F 274 | <p>Continued From page 7</p> <p>were discharged from a hospice program (end of life care).</p> <p>The findings include:</p> <p>A review of the "Long Term Care Resident Assessment Instrument User's Manual (MDS 3.0)," dated April 2012, revealed a significant change in status assessment must be performed when a resident receiving hospice services was discharged from those services and remained a resident at the facility. The manual also revealed the assessment reference date must be no later than 14 days from the date the resident was discharged from the Hospice program.</p> <p>1. Review of Resident #12's medical record revealed Resident #12 was admitted to hospice services on 06/06/11 related to a diagnosis of End-Stage Chronic Obstructive Pulmonary Disease. Review of the physician's orders dated 11/08/13 revealed Resident #12's physician requested hospice services to be discontinued for Resident #12. A review of MDS assessments revealed staff had completed a quarterly assessment on 12/02/13, 24 days after the resident's discharge from Hospice; however, documentation revealed staff failed to complete a significant change assessment within 14 days of the resident's discharge from Hospice as required.</p> <p>2. A review of the medical record for Resident #6 revealed the facility admitted the resident on 05/03/12 with diagnoses that included Alzheimer's, Diabetes, Chronic Renal Failure, History of Kidney Cancer, Upper GI bleed, and a Right Nephrectomy. A review of the physician's orders revealed the physician requested Hospice</p> | F 274 | <p>F-274</p> <p>1. Resident #12 and Resident #6 have MDS and Care Plan that accurately reflects their current status and payor source.</p> <p>2. All resident assessments have been reviewed to ensure a comprehensive assessment has been completed within 14 days after a significant change in status was determined to have occurred.</p> <p>3. An in-service was conducted on January 10, 2014 by corporate RAI/CQI Consultant regarding the completion of significant change assessments as defined per the RAI Manual. Regulations were reviewed including</p> | 2/7/14 |

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| F 274 | <p>Continued From page 8</p> <p>services for Resident #6 on 06/14/11 due to Alzheimer's. Continued review of physician's orders revealed the physician requested for Resident #6 to be discharged from hospice services on 11/22/13. A review of MDS assessments revealed staff had completed a quarterly MDS assessment for Resident #6 on 01/02/14, 41 days after the resident's discharge from Hospice; however, documentation revealed staff failed to complete a significant change assessment within 14 days of the resident's discharge from Hospice as required.</p> <p>An interview conducted with the MDS Coordinator on 01/10/14 at 4:30 PM, revealed she was responsible to complete MDS assessments of the residents. The MDS Coordinator stated she had not been aware a significant change in status assessment was required for residents when they were discharged from hospice programs.</p> <p>An interview conducted with the facility's Corporate Consultant on 01/10/14 at 10:30 AM, revealed she was not aware of the requirement for a significant change assessment to be conducted when a resident was discharged from the hospice program. The Corporate Consultant stated the facility has no specific policy related to MDS assessments, but followed the Resident Assessment Instrument Manual guidelines.</p> <p>An interview conducted with the Director of Nursing (DON) on 01/10/14, at 4:40 PM, revealed she monitored MDS assessments randomly to ensure the assessments were completed within the required timeframe and had not identified any concerns. The DON also stated she was not aware that a significant change in status</p> | F 274 | <p><u>F-274</u></p> <p>Significant change assessment related to initiation and /or discontinuation of hospice services.</p> <p>4. A CQI Committee designee will review residents for a noted change of care needs to ensure a significant change assessment has been scheduled and completed timely per RAI guidelines. These audits will be done on 6 charts weekly chosen at random for one month and then monthly for one quarter. Any irregularities will be corrected immediately and reported to the CQI Committee for further review.</p> <p>5. Date of Completion: February 7, 2014</p> | 2/7/14 | |

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| F 274 | Continued From page 9 assessment was required when a resident was discharged from a hospice program. | F 274 | | |
| F 441 SS=D | 483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of | F 441 | F-441 1. Resident # 13 received clean nasal cannula and oxygen tubing. LPN # 1 has been re-inserviced on infection control practices. 2. All residents utilizing oxygen services will have cannula and tubing changed every week and as needed in accordance with Infection Control policies and procedures. All licensed nursing staff have been re-educated on proper infection control program standards that help prevent the development and transmission of disease and infections. 3. An in-service was conducted on January 15, 2014 by the Infection Control Nurse for all licensed nursing staff. | 2/7/14 |

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749 | | |
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| F 441 | <p>Continued From page 10 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to implement their infection control program related to care of oxygen tubing for one (1) of seventeen (17) sampled residents (Resident #13). Observation on 01/08/14 revealed when Licensed Practical Nurse (LPN) #1 replaced Resident #13's oxygen cylinder, the resident's nasal cannula and oxygen tubing fell and came into direct contact with the floor. LPN #1 picked the tubing up from the floor and reapplied the nasal cannula to Resident #13's nostrils; however, LPN #1 failed to disinfect or replace the nasal cannula or oxygen tubing.</p> <p>The findings include:</p> <p>Review of the Infection Control Program policy (not dated) revealed the facility was to investigate, control, and prevent infections in the facility. The policy further stated environmental surfaces including bedside equipment should be cleaned appropriately.</p> <p>Review of the "Policy for Changing Oxygen Tubing" (not dated) revealed the nurse would ensure that the tubing was changed timely and would change the tubing as needed.</p> <p>Observation on 01/08/14 at 12:00 PM revealed during the process of changing Resident #13's oxygen cylinder, LPN #1 removed the end of the oxygen tubing from the oxygen cylinder that had</p> | F 441 | <p>F-441</p> <p>The in-service included providing proper oxygen services and the need to replace immediately any supplies that may become contaminated while providing care to residents. The in-service reviewed Infection Control Program Standards that help prevent the development and transmission of disease and infection.</p> <p>4. A CQI Committee designee will observe 5 residents per week for one month receiving oxygen services including changing of oxygen supplies. The observations will also include ensuring that all services are provided in accordance with the Infection Control Program standards that</p> | 2/7/14 | |

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

PRINTED: 01/27/2014
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| F 441 | <p>Continued From page 11</p> <p>been in use and the entire tubing, including the nasal cannula, fell and came into direct contact with the floor. LPN #1 picked the oxygen tubing up from the floor but failed to cleanse or replace the tubing and nasal cannula before she reapplied the nasal cannula to Resident #13's nostrils.</p> <p>Interview with LPN #1 on 01/10/14 at 12:45 PM revealed if a nasal cannula or oxygen tubing fell to the floor, staff should replace the nasal cannula and tubing prior to resident use. LPN #1 stated she was unaware the oxygen tubing had fallen on the floor and did not realize she had picked up the tubing from the floor and replaced the nasal cannula into Resident #13's nostrils on 01/08/14.</p> <p>Interview with the Unit Manager on 01/10/14 at 9:45 AM revealed any time oxygen tubing or nasal cannulas fall to the floor, the tubing and nasal cannula should be replaced.</p> <p>Interview with the Infection Control Nurse on 01/10/14 at 2:00 PM revealed the nurses have been taught to change the oxygen tubing weekly and "as needed." According to the Infection Control Nurse, staff should promptly replace any oxygen tubing and/or nasal cannulas that fall to the floor. The Infection Control Nurse stated administrative staff monitors for infection control issues and if any are identified, they are corrected immediately and an in-service conducted. The Infection Control Nurse stated the facility had not identified any concerns related to the use of resident equipment, including oxygen tubing and nasal cannulas, that had fallen and come into direct contact with soiled areas, including the floor.</p> | F 441 | <p>help prevent the development and transmission of disease and infection. After one month, 5 residents will be observed monthly for three months. Any irregularity will corrected immediately and reported to the CQI Committee for further review.</p> <p>5. Date of Completion: February 7, 2014</p> | 2/7/14 | |

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| F 441 | Continued From page 12 Interview with the Administrator on 01/10/14 at 3:45 PM revealed oxygen tubing should be replaced when it hits the ground. The Administrator said administrative staff monitors for infection control issues during daily rounds. According to the Administrator, no issues had been identified with oxygen tubing hitting the ground in the past. | F 441 | | |
| F 469 SS=E | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's pest control contract it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Gnats were observed in the men's shower room and in hallways of the facility. The findings include: An interview conducted with the Administrator on 01/10/14 at 1:44 PM revealed the facility did not have a policy or procedure regarding pest control. According to the Administrator, a contracted pest control company treated the facility on a monthly basis for pests. A review of the facility pest control contract dated | F 469 | F-469 1. The men's shower room and the hallways have been thoroughly cleaned with chemicals and gnats have been eliminated in the men's shower room, 100 Hallway, around the nurses' station and the medication carts. Approved chemicals were placed in the drains in the men's shower room to eliminate gnats. 2. The facility has been thoroughly cleaned. Approved chemicals have been purchased and poured into drains in an attempt to decrease / reduce gnats in all areas. Additionally, safe and appropriate chemicals have been placed in various areas of the facility to decrease / reduce any gnats from populating these areas. | 2/7/14 |

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

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| F 469 | <p>Continued From page 13</p> <p>03/15/05, and ongoing, revealed the facility was treated monthly for pests to include mice, rats, roaches, ants, and crickets; however, the contract failed to address gnats in the facility. A review of a facility purchase order revealed the facility had purchased 24 fruit fly traps on 06/24/13 in an attempt to control gnats.</p> <p>Observation during the evening meal service conducted on 01/08/14 at 5:04 PM revealed a gnat flying in the air near the nurses' station.</p> <p>Observations of the men's shower room on 01/09/14 at 10:50 AM revealed four gnats near the shower drain in the men's shower room.</p> <p>Observation of a medication pass conducted on 01/09/14 at 1:20 PM revealed a gnat flying near the medication cart.</p> <p>Observation on 01/10/14 at 10:40 AM revealed a gnat was observed flying in the 100 Hallway of the facility.</p> <p>A group interview conducted with seven alert and oriented residents on 01/09/14 at 9:30 AM revealed the facility had problems with gnats and the facility had not addressed the problem to rid the facility of gnats.</p> <p>An interview conducted with the Housekeeping Supervisor on 01/10/14 at 1:30 PM revealed she was responsible to monitor the facility for pests and was aware there were gnats in the facility. The Housekeeping Supervisor stated she had placed fruit fly traps in resident rooms but was not aware of when she had placed the traps, had no record of rooms the traps had been placed in, and had not monitored the traps for effectiveness.</p> | F 469 | <p>F-469</p> <p>3. In-service education has been conducted by Administrator with all management staff in regard to pest control management. All staff were in-serviced by department heads for specifics related to their individuals departments regarding pest control and maintaining an effective pest control program. All staff have been instructed to report any observed gnats or pests to their supervisor and / or the housekeeping supervisor. The Housekeeping Supervisor will immediately ensure that the area is cleaned and provide appropriate chemical to eliminate any pests.</p> | 2/7/14 | |

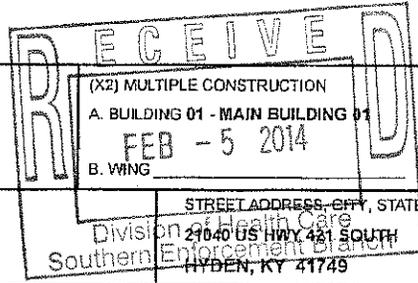
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 469 | Continued From page 14 Further interview with the Housekeeping Supervisor revealed the contracted pest control company did not treat the facility for gnats. A tour with the Housekeeping Supervisor revealed three fruit fly traps in resident rooms. | F 469 | <u>F-469</u> 4. A CQI committee designee will be responsible for making daily rounds of the facility to observe for any signs of pests including gnats. The rounds will be made daily for one month and then weekly for three months. Any signs of pests or gnats will be corrected immediately and the area treated for pest control. Any area noted to not be free of pests will be reported to the CQI Committee for further review. 5. Date of Completion: February 7, 2014 | 2/7/14 | |

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

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| K 000 | INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1986 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (000) SMOKE COMPARTMENTS: Four COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: (2) Type II diesel generators A life safety code survey was initiated and concluded on 01/08/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "D" level. | K 000 | | |
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour | K 029 | <u>K-029</u> 1. The corridor storage room door near the nurses' station is now equipped with a self closing device. 2. All hazardous area doors are now equipped with a self-closing device. 3. In-service education was conducted with the Director of Maintenance on January 10, 2014 regarding hazardous areas being equipped with a self-closing device on the doors. In-service was conducted by Maintenance Consultant. 4. A CQI Committee designee will review hazardous storage areas | 2/7/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa J. Sparks TITLE: Administrator (X6) DATE: 2-5-14

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.

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

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| K 029 | <p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door was equipped with a self-closing device. This deficient practice affected one (1) of four (4) smoke compartments, staff, and approximately twenty-six (26) residents. The facility has the capacity for 94 beds with a census of 85 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/08/14 at 1:10 PM, with the Director of Maintenance (DOM), a corridor storage room door near the nurses' station was observed not to have a door-closing device. Door-closing devices are required on corridor doors to rooms deemed to be a hazardous area. An interview with the DOM on 01/08/14 at 1:10 PM revealed he was aware of this requirement, however, he was not aware this storage room door was in need of a door-closing device.</p> | K 029 | <p>to assure that all doors to the areas are equipped with self-closing devices. The hazardous <u>K-029</u> storage area doors will be checked for equipment and properly working self-closures weekly for one month and then monthly for three months. Any irregularity will be corrected immediately by the Director of Maintenance and reported to the CQI Committee for further review.</p> <p>5. Date of Completion: February 7, 2014</p> | 2/7/14 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| K 029 | Continued From page 2 The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. | K 029 | K-038 1. The door to the clean linen room has been equipped with a self-closing device. 2. Corridor doors have been checked to assure that exits are readily accessible at all times and that all doors are equipped with self-closing devices or open to within 7 inches of wall in the fully open position. 3. In-service education was conducted with the Director of Maintenance on January 10, 2014 by the Maintenance Consultant regarding exit access and | 2/7/14 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| K 029 | Continued From page 3 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas. | K 029 | 4. A CQI Committee designee will check all corridor doors and K-038 exits to assure that all exits are readily accessible at all times. The review will include corridor doors not opening to more than seven inches of corridor walls in the fully open position. Any doors opening to more than seven inches will be equipped with a self-closing device. The review will be done weekly to ensure compliance for one month and then monthly for three months. Any irregularity will be corrected immediately by the Director of | 2/7/14 |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were maintained according to NFPA standards. This deficient practice affected one (1) of four (4) smoke compartments, staff, and approximately twenty-six (26) residents. The facility has the capacity for 94 beds with a census of 85 on the day of the survey. The findings include: During the Life Safety Code tour on 01/08/14, at 1:00 PM, with the Director of Maintenance (DOM), a door to the clean linen room was observed to open into the corridor and failed to open to within seven inches of the corridor wall in the fully open position. This condition could impede egress in an emergency and requires a | K 038 | | |

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| K 038 | <p>Continued From page 4</p> <p>door-closing device to remedy the situation. An interview with the DOM on 01/08/14, at 1:00 PM revealed the DCM was aware of this requirement, however, he was not aware this door was in need of a door-closing device.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.4.4*</p> <p>During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)</p> <p>Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.</p> | K 038 | <p>Maintenance and reported to the CQI Committee for further review.</p> <p>5. Date of Completion: February 7, 2014</p> | 2/7/14 |