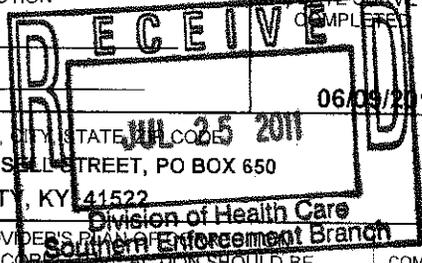


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
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F 000	INITIAL COMMENTS	F 000	<p><u>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</u></p> <p>Tag # F 204</p> <ol style="list-style-type: none"> No other resident's were found to have been adversely affected by this practice. Resident # 19's primary physician was notified by the Social Services Director to ensure that resident # 19 received needed services after leaving this nursing facility. Social Services Director will maintain a current log of all resident's with the potential or planned discharge to home. Social Services Director will discuss discharge list daily (Monday through Friday) with the discharge 	
F 204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review, interview, and facility policy review, the facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility for one of 24 sampled residents. Resident #19 was discharged from the facility on April 15, 2011, without instructions on taking/obtaining medications/treatments or lab exams, follow-up care, or referrals.</p> <p>The findings include:</p> <p>A review of the Discharge/Transfer Policy (no date) revealed a physician's order should be obtained prior to resident discharge. The policy noted the facility staff should ask the physician whether the resident's medications were to be sent with the resident upon discharge and this information should be documented on the physician's order. The policy further stated a discharge summary would be completed. The discharge summary should include a list of medications with simplified instructions and restrictions for post discharge care. The policy</p>	F 204		



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

[Handwritten Signature]

TITLE

Administrative

(X6) DATE

07-21-11

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 204	<p>Continued From page 1</p> <p>noted the discharge summary would be signed by the resident and/or the representative.</p> <p>A review of the closed medical record for resident #19 revealed the resident was admitted to the facility on October 15, 2010, with diagnoses to include Syncope, Arthritis, Non-Hodgkin's Lymphoma, Coronary Artery Disease, Deep Vein Thrombosis, Hypothyroidism, and Depression. A review of the comprehensive Minimum Data Set (MDS) assessment dated March 18, 2011, revealed resident #19 was assessed to have a score of 14 for mental status, which indicated the resident was oriented. The MDS further revealed the facility assessed resident #19 to require the extensive assistance of one person for transfers, bed mobility, ambulation, dressing, and hygiene.</p> <p>A review of the April 2011 physician's orders revealed resident #19 had daily alternating doses of Coumadin, 4 mg one day alternating with 5 mg the next day, and to check the INR levels per physician's orders. The physician also prescribed Zocor 40 mg daily, Megace ES 625 mg/5 milliliters (ml) daily, Prostat 101 30 ml twice a day, Lopressor 12.5 mg twice a day, Aspirin 81 mg daily, Paxil 20 mg daily, Nexium 40 mg daily, Claritin 10 mg daily, Synthroid 75 micrograms (mcg) daily, Neurontin 300 mg every 12 hours, Evista 60 mg daily, and Albuterol Sulfate 2.5 mg/3 ml Nebulizer treatment every four hours. In addition, the physician had ordered Physical Therapy (PT) and Occupational Therapy (OT) services five days a week for neuromuscular re-education, gait/transfer weakness training, and therapeutic exercises. A physician's telephone order was written on April 15, 2011, to discharge the resident and "belongings" home to the</p>	F 204	<p>team during the morning meeting to ensure residents being discharged have all needed home interventions prior to discharge.</p> <p>3. The Staff Development Coordinator inserviced nursing, social services, dietary, therapy, and activities on July 8, 2011 related to the correct usage of the Discharge Assessment Summary and Discharge Instruction forms to ensure all services the resident may require upon discharge have been implemented. The Director of Social Services will ensure that residents receive all needed services such as home health services, transport, special equipment, etc. prior to discharge. The Dietary Manager will discuss ordered diets and all preferred foods that are permitted with that diet. The Rehab Manager will share input on recommended services for exercises to maintain resident at highest functioning level and to ensure safe transition to home environment. Unit Managers will ensure all ordered medications have been called in to pharmacy of resident/family choice and/or prescription obtained for all needed medications, make follow-up appointment with primary care physician, and provide education on medications, needed labs, and benefits and consequences of</p>		

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F 204	<p>Continued From page 2</p> <p>resident's family. However, the physician's order failed to include information regarding the resident's medications per facility policy.</p> <p>A review of the PT progress note dated April 18, 2011, revealed the PT noted the exercise plan had been reviewed with the resident and a theraband had been supplied for the resident to use for exercises. The PT note further stated safety precautions for activities in the home and community to prevent falls had been reviewed with resident #19. The OT note dated April 17, 2011, revealed resident #19 had progressed well with treatment and had met all goals to return home for independent living.</p> <p>A review of the nurse's notes dated April 15, 2011, at 5:30 p.m., revealed resident #19 was discharged from the facility with the resident's daughter per family request. The nurse's notes stated the resident's belongings were sent with the resident. However, there was no evidence the nurse provided information to the resident or the resident's daughter regarding instruction for obtaining medications, the need for follow-up lab tests, or therapy services for the resident.</p> <p>A review of the social services notes dated April 15, 2011, revealed resident #19 was discharged home to an apartment. However, there was no evidence the Social Services Director (SSD) had made any referrals to the resident's physician or home health services to ensure the resident's care needs were maintained after discharge from the facility.</p> <p>A review of the discharge summary revealed a copy of the information had been provided to the</p>	F 204	<p>keeping follow-up appointments, and to ensure that no blanks are left on the Discharge Assessment Summary and Discharge Instruction Form). The discharge from will be reviewed with resident and/or, family with needed education provided before and upon discharge.</p> <p>4. Audits will be completed by the Executive Director/Director of Nursing/ Designee daily (Monday through Friday) x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all potential and planned discharged resident's records to ensure completion of discharge forms and that the discharged resident's home needs are met.</p> <p>The results of the audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>		

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F 204	<p>Continued From page 3</p> <p>resident's daughter. However, the medication list was left blank and the sections regarding special treatments, rehabilitation information, and dietary information was also left blank.</p> <p>An interview conducted with the Social Services Director (SSD) on June 9, 2011, at 5:30 p.m., revealed she was responsible to make any referrals when a resident was discharged from the facility. The SSD stated she did not make any referrals for resident #19 when the resident was discharged on April 15, 2011.</p> <p>An interview conducted with LPN #6 on June 9, 2011, at 5:45 p.m., revealed the LPN had written the telephone order for discharge for resident #19. LPN #6 stated a physician's order and discharge summary were required when a resident was discharged from the facility. LPN #6 stated she could not recall if instructions regarding the resident's medications, lab, therapy, or diet had been provided when the resident was discharged from the facility. The LPN stated the discharge summary should be completed by each discipline and reviewed with the resident or family member. LPN #6 stated no medications were sent with a resident upon discharge.</p> <p>An interview conducted with the Director of Nurses (DON) on June 9, 2011, at 6:15 p.m., revealed a physician's order should be obtained when a resident was discharged from the facility. The DON stated the facility should send at least enough medications to last until the resident had been able to see their attending physician and the medications, care needs, and home health referrals should be discussed with the resident and/or family member.</p>	F 204			

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F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure one of 24 sampled residents was free from physical restraints not required to treat a medical symptom (resident #15). Observations of resident #15 revealed the resident to be in a Broda chair with straps placed over the resident's legs. However, the facility failed to assess the resident for the presence of a medical symptom that required the use of a restraint device, and how the restraint use would treat the medical symptom and protect the resident. There was no evidence the facility assessed for the least restrictive alternatives or the appropriateness of the restraints for resident #15.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure (no date given) revealed physical restraints were defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which would restrict freedom of movement or normal access to one's body. The policy stated physical restraints included but were not limited to leg/arm restraints, hand mitts, soft ties or vests, lap cushions, lap</p>	F 221	<p><u>Tag # F 221</u></p> <ol style="list-style-type: none"> 1. Resident # 15's physician was notified related to the need for Broda Chair with thigh straps. An order was obtained on 6/27/2011 to continue the use of a Broda Chair with bilateral thigh straps related to dementia, atrial fibrillation with history of edema, and decreased mobility. Bilateral thigh straps were found to be needed for this resident secondary to decreased safety awareness and for use as a positioning device. The assessment and care plan's were updated on 6/27/2011 to reflect the continued need for the Broda Chair with bilateral thigh straps for this resident. 2. The MDS nurse completed a 100% audit on 6/27/2011 for all residents who currently require the use of a Broda Chair with bilateral thigh straps. The assessment and care plans for these residents were updated to reflect the continued need for Broda Chair with bilateral thigh straps. 3. The Staff Development Coordinator will inservice all licensed nurses on or before July 8, 2011 related to the use of Broda Chair with bilateral 		

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

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F 221	<p>Continued From page 5</p> <p>trays the resident could not remove, bedrails which prevent a resident from voluntarily getting out of bed, wheelchair safety bars, or placing a resident in a chair that would prevent rising. The policy/procedure regarding restraint use further revealed the interdisciplinary team (IDT) was to complete the Physical Restraint RAP Module when assessing the need for physical restraints and make recommendations to the physician and family based on the results of the assessment. The charge nurse was to obtain a physician's order that included the specific type of restraint, its specific use, and the medical symptoms that warranted the use of a restraint.</p> <p>Resident #15 was observed on June 9, 2011, at 1:30 p.m., to be sitting in a Broda chair with bilateral straps across the resident's thighs. The resident was being fed by facility staff during the noon meal.</p> <p>A review of the medical record revealed resident #15 was admitted to the facility on June 12, 2009, with diagnoses to include Depressive Disorder, Alzheimer's Disease, Hypertension, Lack of Coordination, Senile Dementia, and Vertigo. A review of a significant change Minimum Data Set (MDS) assessment completed on October 8, 2010, revealed the facility assessed resident #15 to require extensive assistance of two staff persons for bed mobility, transfers, ambulation, and toileting. In addition, the resident was assessed to have no impairments with range of motion and did not require the use of a restraint. A review of the quarterly MDS assessment completed on March 27, 2011, revealed the facility assessed resident #15 to continue to require extensive assistance of staff for bed</p>	F 221	<p>thigh straps, completion of the assessment, and care plans. The MDS nurse will maintain a log of all residents who presently requiring a Broda Chair with or without bilateral thigh straps or any new residents identified by therapy to require a Broda Chair with or without bilateral thigh straps.</p> <p>The assessment and care plans will be completed by the MDS nurse or designee upon initiation of a Broda Chair with or without thigh straps and then quarterly thereafter.</p> <p>4. Audits will be completed by the Director of Nursing or designee daily (Monday through Friday) x 4 weeks, weekly x 4 weeks, then monthly x 4 months to ensure that all residents requiring a Broda Chair with or without thigh straps have the appropriate assessment and care plans completed.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>		

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F 221	Continued From page 6 mobility, transfers, ambulation, and toileting. The assessment further revealed resident #15 was assessed to require a chair to prevent rising. Further review of the medical record revealed a restraint evaluation and consent form had been conducted on February 22, 2011, for the use of a lap buddy for resident #15. The evaluation revealed resident #15 required the use of a lap buddy when the resident was out of bed to prevent attempts to self-transfer independently. A review of the quarterly restraint evaluation conducted on March 29, 2011, revealed the lap buddy was discontinued and the Broda chair with bilateral thigh straps had been implemented. However, there was no evidence the facility had conducted an assessment to evaluate the Broda chair with thigh straps as a possible restraint device for the resident. Interviews conducted with Certified Nurse Aide (CNA) #1 on June 9, 2011, at 1:35 p.m., revealed resident #15 was not able to ambulate independently. CNA #1 stated the resident would stand up without assistance if the Broda chair and thigh straps were not in use. The CNA stated resident #15 had been in the Broda chair for approximately four months. An interview conducted with the MDS nurse (LPN #7) on June 9, 2011, at 1:45 p.m., revealed the Broda chair with thigh straps had been implemented due to the request of the resident's family. LPN #7 stated no restraint assessment had been conducted prior to the implementation of the Broda chair with thigh straps.	F 221			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225			

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F 225	<p>Continued From page 7 ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported 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>	F 225	<p><u>Tag # F 225</u></p> <ol style="list-style-type: none"> 1. Resident # 24 was found to not be adversely affected by this practice. No residents were found to be adversely affected by this practice. The facility conducted an investigation on resident #24's spouse. Investigation revealed that spouse did not obtain any of residents medications. Resident's spouse did not return to the facility. 2. Nursing Administration conducted a 100% review of all active residents' charts for any documentation alleging abuse, neglect, or misappropriation. No other resident's were found to have been affected by this practice. <p>In the future, if any visitor or family member enters facility impaired the Executive Director will be notified by staff. The Executive Director or Social Services Director will initiate an investigation including faxing initial investigation to OIG/APS.</p> <p>Please note: APS was notified by the Social Services Director about this occurrence and did not choose to make a visit to this nursing facility.</p>	

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F 225	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse were immediately reported to officials in accordance with state law. Allegations of misappropriation involving resident #24 were reported to Facility Administration; however, the facility failed to thoroughly investigate or report the allegation to state agencies as required.</p> <p>The findings include:</p> <p>A review of the facility's abuse/neglect prevention policy revealed the Executive Director (ED) was required to ensure state agencies were notified immediately of all allegations of abuse/neglect and misappropriation of property. In addition, the ED was required to direct the investigation into all allegations.</p> <p>A review of the facility's investigations revealed an incident occurred on April 12, 2011, while resident #24's spouse was visiting. According to the facility report, resident #24's spouse was obviously impaired while visiting resident #24. The spouse was staggering, crawled under the resident's bed, and was dropping and spilling things. In addition, according to the report, it was alleged the spouse was crushing pills and snorting them in his/her nose. A second paragraph in the report stated the facility's Social Worker (SW) spoke to the resident's family member, who told the SW the resident's spouse had stolen a prescription for Xanax and Percocet from the resident when the spouse had accompanied the resident on a physician visit</p>	F 225	<p>3. The Staff Development Coordinator will complete an inservice on or before July 8, 2011 for all staff related to the reporting and investigation process.</p> <p>Staff will notify Executive Director or designee immediately of any impaired visitors. An investigation will be initiated immediately with initial investigation reported to OIG and APS with 5 day follow-up completed thereafter.</p> <p>The Regional Director of Clinical Services inserviced the Executive Director and Social Services Director related to reporting, initiating, and completing a thorough investigation on 6/27/11.</p> <p>4. Audits will be conducted by the Executive Director or designee daily x 4 weeks, weekly x 4 weeks, then monthly x 4 months of the shift reports, morning meeting, self reports to ensure investigations are initiated timely when an incident occurs.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance</p>	

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F 225	<p>Continued From page 9</p> <p>recently. According to the report, the resident's spouse had the prescriptions filled. There was no documentation in the facility's Investigations File that the incident was reported to the Office of Inspector General (OIG) or that a thorough investigation into the incident was conducted by the facility.</p> <p>An interview with the facility's SW conducted on June 9, 2011, at 4:10 p.m., revealed the SW was instructed by Administration to call Adult Protective Services and that there was no need to call OIG. The SW further stated that she only notified state agencies when she was directed to by Administration. The SW stated, "I don't take it on myself to decide to call."</p> <p>An interview with the Director of Nursing (DON) conducted on June 9, 2011, at 4:15 p.m., revealed the SW was the person designated to notify state agencies of allegations, but that sometimes the DON notified them. However, the DON did not notify state agencies of the incident related to resident #24.</p> <p>Interviews conducted with the Executive Director (ED) on June 9, 2011, at 4:55 p.m., 5:25 p.m., 6:20 p.m., and 7:15 p.m., revealed the ED investigated the incident but had no documentation of the investigation. The ED stated the facility called the Police Department, who came to the facility and took the spouse to jail. The ED also instructed the facility staff not to allow the resident's spouse to return to the facility. According to the ED, she did not obtain statements from staff because she believed since the spouse was not allowed to visit the ED had done everything she needed to do. The ED did</p>	F 225	<p>Improvement Committee determines compliance.</p> <p>5. Date of Compliance- July 22, 2011.</p>		

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

PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 10 not see the incident as an allegation of misappropriation since the incident involved the resident's spouse, and did not feel the state survey agency needed to be notified. The ED further stated the allegation was not true about the stolen prescriptions because the nurses called the physician to confirm no prescriptions were given. The ED was unable to remember with whom she spoke or what was said. The ED stated she did not have any documentation regarding an investigation into the allegation.	F 225	<p align="center">Tag # F 253</p> <p>1. A 100% audit of the facility including the resident rooms was completed on 6/30/2011 by the Executive Director and Maintenance Director to ensure that all doors with chipped wood, broken toilet paper dispensers, walls for loose wall boards, wheelchairs for torn or missing armrests, cracked walls, chipped tiles and doors, courtyard draining water underneath doors, wallboards pulled away from the floor, holes in the wall, chipped paint, brown discoloration on the wall and soft to touch, torn wallpaper, outside door hard to open and sticking, outside gutters, and cracked tiles have been identified and a plan put into place to correct issues.</p> <p>All residents had the potential to be affected by this practice</p> <p>Please note: The gutter was unstopped by maintenance on the day of the thunderstorm which stopped leakage under dining room doors. An outside contractor was contracted by the Executive Director on June, 10, 2011 to assess the gutter and doors in courtyard for need to replace or repair. No need</p>		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Ten doors were observed to have chipped wood, four broken toilet paper dispensers were observed, four walls were observed to have loose wallboards, four wheelchairs were observed to have torn or missing armrests, one room was observed to have a cracked wall, two rooms were observed to have chipped tile, two doors leading to the courtyard were observed to have water draining underneath the doors, one wallboard was observed to be pulled away from the floor, one room was observed to have a hole in the wall,	F 253			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	<p>Continued From page 11</p> <p>one room was observed to have chipped paint, one room was observed to have a portion of the wall brown in color and soft, one room was observed to have torn wallpaper, one outside door was observed to be hard to open and sticking, and a portion of the outside gutter was observed to be draining onto the patio during the environmental tour on June 9, 2011.</p> <p>The findings include:</p> <p>A review of the facility's policy, Identified Problems, (no date) revealed the Maintenance Department was responsible to make rounds of the grounds every morning, and to respond to and correct all identified problems, in a timely manner. The policy further revealed the Maintenance Department would make rounds of the grounds every day and any hazardous conditions would be noted and corrective action would be taken immediately. The policy also revealed in response to work order requests, the Maintenance Department would inspect damaged or malfunctioning equipment to determine if repairs or adjustments were needed. The policy revealed evidence of the actions taken to resolve identified problems could be located in the Daily Inspection Report Log, the completed Work Order File, or the Utilities Management Failure User Error Log, which is a synopsis of the major problem resolution activities.</p> <p>During the environmental tour of the facility on June 9, 2011, at 3:15 p.m., the following items were observed to be in need of repair:</p> <p>-Chipped wood on resident room doors was observed in resident rooms 203, 208, 404, 406,</p>	F 253	<p>for replacement or repair of gutters/doors at this time.</p> <p>2. Maintenance Director met with contractor on 7/5/11 to determine environmental issues that need to be addressed. All chipped doors will be replaced; all toilet dispensers were replaced; housekeeping has extra spindles on carts to replace as needed; all loose baseboards were replaced; all wheelchairs with broken armrests were replaced; all chipped drywall, torn wallpaper, paint and chipped tile issues are being repaired; the exit doors in the hallway across from the dining room have been ordered new adjustable thresholds to seal bottom of doors properly; and gutters and drains in the courtyard were all cleaned and are working properly..</p> <p>3. The Staff Development Coordinator will inservice all staff on or before July 8, 2011 regarding how to complete a work order and who to turn in it to.</p> <p>A maintenance log will be maintained by the Executive Director/Maintenance Director for all maintenance requests.</p> <p>Facility rounds will be conducted daily Monday through Friday by the</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 12 409, 411, 603, 607, and 610. -Chipped wood was observed on the door to the Central Bath on the Faith Wing of the facility. -Toilet paper dispensers were observed to be broken in the bathrooms in resident rooms 403, 602, 603, and 614. -Loose baseboards were observed in resident rooms 403 and 610 under the sink, in resident room 607 under the air conditioner unit, and around the closet in resident room 609. -Resident room 603 was observed to have paint chipped on the wall on the left side of the door. -Resident room 602 was observed to have a hole in the wall on the left side of the window. -Resident room 611 was observed to have the wall cracked under the sink and the wallpaper torn above bed 2. -Resident rooms 403 and 607 were observed to have cracked tile under the air conditioners in the rooms. -Resident room 602 was observed to have wallboard pulled away from the floor under the sink. -Resident room 409 was observed to have a portion of the wall under the air conditioner unit brown in color and soft to the touch. -The outside door by the sink in the large dining room of the facility was observed to stick when trying to open it. -Water was observed to be coming under a door leading to the courtyard in front of the kitchen, and also under the door in front of the sink in the large dining room, from rain outside during a thunderstorm. -The drain for the gutter in the courtyard was observed to be stopped up and water was observed to be draining onto the patio. -A wheelchair in resident room 204 was observed	F 253	Management Team. Maintenance will update request log and report to Executive Director upon completion of issues. 4. The management team will conduct facility audit daily, Monday through Friday,. These audits will be maintained by the Executive Director. The Executive Director/ Maintenance Director will conduct random audits of 5 resident rooms Monday through Friday daily x 4 weeks, weekly x 4 weeks, then monthly x 4 months then randomly. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance – July 22, 2011.		

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F 253	Continued From page 13 to have the right armrest missing. -Wheelchairs in resident rooms 404, 803, and the bathroom of resident room 404 were observed to have torn armrests in need of repair. An interview conducted with the Maintenance Supervisor (MS) for the facility on June 9, 2011, at 4:15 p.m., revealed the facility utilized a work order system. The MS stated any staff member could obtain a work order at the nurses' station to inform the Maintenance Department of anything that needed to be repaired. The MS stated the employees would then place the work order in a box outside the Maintenance Department. The MS stated he/she checked the box several times a day for work requests, and also conducted a daily walkthrough on each nursing unit.	F 253	Tag # F 281 1. The physician was notified of incorrect medication administration via g-tube. No further orders were obtained. Nursing staff to continue seizure precautions. Resident # 2 was not found to have been adversely affected by this practice. No other residents were found to have been adversely affected by this practice. 2. A 100% observation will be completed by July 15, 2011 of all licensed nurses by the Director of Nursing or designee performing a medication pass. Observations will be made to ensure auscultation of G-tube placement prior to the administration of medication and rinsing of medication cup after administration to ensure resident receives all of medication. Any licensed nurse not observed completing a medication pass by July 15, 2011 will not be permitted to work until an observation has been completed. 3. The Staff Development Coordinator will inservice all licensed nurses on or before July 8, 2011 related to the policy and procedure of medication administration including but not	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to meet accepted professional standards of quality for one of twenty-four sampled residents. The facility staff failed to verify resident #2's gastrostomy tube placement prior to the administration of medication via the gastrostomy tube. In addition, resident #2 had a physician's order for Keppra, an antiseizure medication, to be administered twice daily; however, the nurse failed to rinse the medication cup after medication administration, which still contained Keppra liquid	F 281		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 14 medication, to ensure prescribed dosage of medication was given.</p> <p>The findings include:</p> <p>A review of the facility's policy on Feeding Tube-Instilling Medication (no date) revealed the placement and patency of gastrostomy tubes should be verified by auscultation prior to medication administration. The policy did not address rinsing of medication cups used to verify liquid medication to ensure proper dosage was given.</p> <p>Resident #2 was admitted to the facility on January 13, 2011, with diagnoses of Traumatic Brain Injury, Seizure disorder, Dysphagia, Gastrostomy Tube Placement, and Stage III Pressure Ulcer. A significant change assessment completed on April 22, 2011, revealed the resident required extensive assistance for all activities of daily living.</p> <p>A review of the facility's policy for Medication Administration with revised date of October 2004 revealed it was the responsibility of the nursing professional to be aware of the correct dosage of medication before administering medication.</p> <p>An observation of a medication pass conducted on June 8, 2011, at 9:30 a.m., revealed Licensed Practical Nurse (LPN) #1 administered medication to resident #2 via the gastrostomy tube route. LPN #1 flushed the resident's gastrostomy tube with water, and then administered each medication. The LPN flushed the resident's gastrostomy tube with water between each medication administered; however,</p>	F 281	<p>limited to auscultation of G-Tubes and rinsing of medication cups of liquid administration.</p> <p>System change: A stethoscope has been assigned to each medication cart for using during G-tube medication pass. Each MAR of residents requiring g-tube medication has an updated order that requires nurse signature that auscultation has occurred prior to the administration of g-tube medications.</p> <p>4. The Director of Nursing or designee will observe medication administration randomly daily (Monday through Friday) x 4 weeks, weekly x 4 weeks, and monthly x 4 months.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>	

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F 281	Continued From page 15 there was no evidence the LPN checked the gastrostomy tube for placement prior to administering the medications. An interview conducted on June 8, 2011, at 9:40 a.m., with LPN #1 confirmed she did not verify resident #4's gastrostomy tube placement prior to administration of the medications. The LPN further revealed gastrostomy tube placement should have been verified prior to administering medication, and medication cups containing liquid medications should be rinsed with water to ensure residents received the correct dose of medication. An interview conducted on June 9, 2011, at 6:20 p.m., with the Director of Nursing (DON) revealed a resident's gastrostomy tube should have been checked to verify proper placement prior to the administration of any medication. The DON further revealed medication cups should be rinsed with water to ensure proper dosage of ordered medication.	F 281	Tag # F 282 1. Resident # 2 was not found to have been adversely affected by this practice. Upon notification of side rails not being padded and care guide assignment not updated, Unit Manager instructed nurse aide to place pads on side rails. Unit Manager updated care guide assignment to reflect residents need for padded side rails. 2. A 100% audit was completed by the Director of Nursing or designee on June 28, 2011 of residents requiring padded side rails to ensure that care guide assignments reflect side rail padding in use. No other residents were identified to not have padded side rails if ordered. 3. The Staff Development Coordinator will inservice all licensed staff on or before July 8, 2011 regarding the use of padded side rails, updating care guide assignments, and ensuring side rails are padded when orders are obtained. The nurse receiving a new resident or a new order related to padded side rails will be responsible to notify to nursing assistant to place pads on side rails. The nurse receiving the order for the pads to		
F 282 SS=D	483.20(k)(3)(ii) 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, and record review, it was determined the facility failed to provide services to one of twenty-four sampled residents in accordance with the resident's written	F 282			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 16</p> <p>plan of care. Review of the written plan of care for resident #2 revealed staff was to ensure resident #2 had two full, padded side rails in use. However, observations on June 7 and June 8, 2011, revealed facility staff had not implemented the intervention as planned for the resident.</p> <p>The findings include:</p> <p>A review of resident #2's medical record on June 7, 2011, revealed the resident was admitted to the facility on January 13, 2011. The resident's diagnoses included Traumatic Brain Hemorrhage, Brain Injury, Seizure Disorder, Dysphagia, Gastrostomy Tube Placement, and Pressure Ulcer-Stage III. Review of resident #2's Admission Minimal Data Set (MDS) assessment dated January 25, 2011, revealed the resident required extensive assistance for bed mobility and transfers.</p> <p>A review of resident #2's plan of care updated on April 15, 2011, revealed the resident was at risk for seizure activity and at risk for complications related to a Stage III pressure ulcer present to the coccyx. Interventions included two full side rails with pads on resident #2's bed added to the plan of care on February 7, 2011.</p> <p>A review of the June 8, 2011 CNA daily assignment sheet revealed resident #2 was to have full side rails. The assignment sheet, however, did not state the side rails were required to be padded.</p> <p>Observations conducted on June 7, 2011, at 2:30 p.m., 3:30 p.m., 4:40 p.m., 5:35 p.m., and 6:30 p.m., revealed resident #2 lying in bed, with two</p>	F 282	<p>side rails will update the care guide assignments. The Unit Manager will follow-up with the order to ensure that pads were placed on side rails and care guide assignments were updated.</p> <p>4. Audits will be completed by the Director of Nursing or designee daily (Monday-Friday) x 4 weeks, weekly x 4 weeks, then monthly x 4 months to observe compliance with side rails and care guide assignments reflecting padded side rails.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>	

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F 282	<p>Continued From page 17</p> <p>side rails raised on the resident's bed. The side rails were observed to have no padding.</p> <p>Continued observations conducted on June 8, 2011, at 9:00 a.m., 10:30 a.m., 11:45 a.m., and 12:30 p.m., revealed no evidence of padded side rails to be in use for resident #2.</p> <p>Interview conducted on June 8, 2011, with CNA #1 at 12:35 p.m., revealed residents' care needs were indicated on the daily assignment sheets. CNA #1 stated night shift CNAs were responsible to have new daily assignment sheets updated and ready for day shift CNAs. CNA #1 was unaware that resident #2's side rails should have been padded.</p> <p>Interview conducted on June 8, 2011, at 12:50 p.m., with CNA #2 revealed the daily assignment sheet was used to inform staff of the residents' care needs. The CNA stated the assignment sheets are updated daily, and they received a new sheet at the beginning of every shift; however, CNA #2 was unaware resident #2's side rails should have been padded.</p> <p>Interview with the Unit Manager on June 8, 2011, at 12:45 p.m., revealed when a new order was received that required a resident's care plan to be revised, the charge nurse at that time was responsible for putting that information in the computer, which updates the care guides for the CNAs. LPN #2 stated she ensured care needs were being met for residents by doing spot checks daily. However, LPN #2 had not identified resident #2's side rails were not padded as required.</p>	F 282			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 18 Interview with the DON on June 9, 2011, at 6:20 p.m., revealed that the nurse who received any new orders was responsible for updating resident care needs in the computer system to ensure new information was printed on the daily assignment sheet for CNAs. The DON stated all new orders that were written were brought into the daily stand-up meeting and reviewed.	F 282	The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy/procedure, the facility failed to provide the necessary services to maintain personal hygiene/grooming for four of twenty-four sampled residents. Residents #3, #7, #8, and #12 were observed to have long dirty fingernails and/or toenails. The findings include: A review of the facility's policy/procedure related to Nail Care (no date) revealed nail care included daily cleaning and regular trimming. The policy further noted licensed nurses were responsible for the diabetic residents' nail care and nursing assistants should not trim the fingernails/toenails of diabetic residents.	F 312	5. Date of Compliance – July 22, 2011.	

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F 312	<p>Continued From page 19</p> <p>1. Resident #3 was observed on June 7, 2011, at 2:45 p.m., 3:47 p.m., and 6:25 p.m., and on June 8, 2011, at 9:00 a.m., 10:20 a.m., 12:25 p.m., and 2:50 p.m., to still have long fingernails with a brown substance underneath the resident's nails.</p> <p>A review of the May CNA Flow Report revealed fingernail care was documented as being provided for resident #3 on May 31, 2011. However, there was no fingernail care documented for the month of June 2011.</p> <p>An interview with CNA #2 on June 8, 2011, at 3:10 p.m., revealed nail care was to be provided on the resident's shower days (Tuesday and Fridays) by the shower aides. CNA #2 stated residents' fingernails were to be checked each day and cleaned/trimmed as needed. The CNA stated she had not provided nail care for resident #3 on June 7 or 8, 2011, and could not recall when she had provided nail care for the resident. The CNA stated nail care was required to be documented on the CNA flow record.</p> <p>An interview with CNA #9 on June 9, 2011, at 3:20 p.m., revealed she was one of the shower aides. CNA #9 stated the CNAs were responsible for cleaning/trimming residents' nails as needed when providing routine care. CNA #9 stated she had provided resident #3 with a shower on June 7, 2011, and observed the resident's nails to be in need of cleaning/trimming; however, CNA #9 did not provide nail care for resident #3.</p> <p>2. A review of the June 2011 CNA Flow Report revealed nail care had been documented as being provided for resident #7 on June 1, 2011</p>	F 312	<p><u>Tag # F 312</u></p> <ol style="list-style-type: none"> Resident's # 3,7,8, and 12 had nail care provided upon notification. No other residents were found to have been adversely affected by this practice. A 100% audit of all residents was completed on June 28, 2011 by the nurse management team to ensure that nail care was completed on all residents. Any nails found in need of being trimmed or cleaned was addressed at time of observation. The Staff Development Coordinator will inservice all staff on or before July 15, 2011 related to nail care (cleaning and trimming). All non-diabetic nail care will be provided by CNA on Shower/Bath days and as needed and documented on Resident Information Tracking Application record. All diabetic nail care will be provided by a licensed nurse weekly and as needed and will be documented on MAR's/TAR's. Audits will be conducted by the nurse management team daily (Monday through Friday) x one week, weekly x 4 weeks, then monthly x 4 months to ensure nail care is provided. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

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F 312	<p>Continued From page 20 and June 7, 2011.</p> <p>However, resident #7 was observed on June 8, 2011, at 12:05 p.m., 1:10 p.m., 2:50 p.m., and 3:30 p.m., to have long, dirty fingernails.</p> <p>Interview on June 8, 2011, at 3:10 p.m., with CNA #2, who was assigned to provide care for resident #7, revealed the shower team was responsible to provide nail care for the residents. CNA #2 stated she was not responsible for nail care for this resident.</p> <p>An interview with CNA #1 on June 8, 2011, at 3:15 p.m., revealed CNA #1 was one of the shower aides. CNA #1 stated resident #7 was scheduled for a shower on Tuesday and Friday. CNA #1 stated both the CNAs and shower aides were responsible for providing nail care for the residents. CNA #1 stated she had provided nail care for resident #7 "last week."</p> <p>An interview conducted with the Director of Nurses (DON) on June 9, 2011, at 6:15 p.m., revealed nail care should be provided by both the CNAs and the shower aides. The DON stated residents' nails should be checked at least weekly and as needed.</p> <p>3. Observation of resident #8 on June 8, 2011, at 2:55 p.m., revealed the resident's toenails were long and in need of trimming.</p> <p>An interview conducted with Licensed Practical Nurse #3 on June 8, 2011, at 4:00 p.m., revealed resident #8 was diabetic; therefore, it was the responsibility of the nurse who worked on Sundays to trim the resident's nails. According to</p>	F 312		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 21 the LPN, the facility podiatrist attempted to trim resident #8's toenails approximately three weeks earlier but the resident refused to allow his/her nails to be trimmed. The LPN further stated if the resident refused to have his/her nails trimmed, then another nurse should have tried and resident #8's family and physician should have been notified if the nurse was unable to trim the resident's toenails. However, LPN #3 stated she had not attempted to trim resident #8's toenails when she worked on Sundays. 4. Observation of resident #12 on June 9, 2011, at 3:10 p.m., revealed the resident's fingernails were long and in need of trimming. An interview conducted with the Unit Manager/Licensed Practical Nurse #2 on June 9, 2011, at 5:50 p.m., revealed resident #12 was diabetic, and it was the responsibility of the nurse who worked on Sundays to trim the resident's nails. The Unit Manager stated he/she ensured that residents' nails were kept trimmed and neat by doing spot checks daily. However, the Unit Manager was unaware that resident #12's nails were in need of trimming. Interview with the Director of Nursing on June 9, 2011, at 6:20 p.m., revealed nurses who worked on Sundays were responsible for performing nail care on diabetic residents and stated all residents should be receiving nail care once a week.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315			

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

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F 315	<p>Continued From page 22</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate incontinence care was provided for one of twenty-four sampled residents. Resident #5 was observed to have soiled linen on the resident's bed with a dried urine circle.</p> <p>The findings include:</p> <p>A review of the facility's Urinary Incontinence policy (no date given) revealed pads, bedding, and clothing were required to be changed promptly for a resident who had experienced an incontinence episode.</p> <p>A review of the medical record for resident #5 revealed the resident was admitted to the facility on September 10, 2007, with diagnoses of Alzheimer's Disease, Hypertension, Anxiety, Depression, and Vertigo. A review of the Minimum Data Set (MDS) assessment dated April 13, 2011, revealed resident #5 was incontinent of bowel and bladder and was on a "check and change program every two hours."</p> <p>Observation of incontinence care for resident #5 on June 8, 2011, at 10:25 a.m., revealed resident</p>	F 315	<p>Tag # F 315</p> <ol style="list-style-type: none"> 1. Resident # 5 was dry and draw sheet was clean and without odor of urine upon investigation. No other residents were found to have been adversely affected by this practice. 2. A 100% audit was conducted by the nurse management team on June 8, 2011 of all residents beds to ensure no dried urine circles were present. No dried urine circles was found on any other residents bed linen. 3. The Staff Development Coordinator will inservice all nursing staff on or before July 8, 2011 related to dried urine circles, incontinence, and changing of bed linens. All bed linens are to be changed when they become soiled, on shower/bath days, and as needed. Oncoming CNA's will perform a walking round with offgoing CNA's assessing residents assigned to them to ensure bed linen is clean. A round sheet will be signed at shift change with walking rounds. 4. Audits will be completed by the nursing management team daily (Monday through Friday) x one week, weekly x 4 weeks, and monthly x 4 months to ensure that 	

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F 315	Continued From page 23 #5 had experienced an incontinence episode and Licensed Practical Nurse/Unit Manager (LPN/UM) #7 and Certified Nursing Assistant (CNA) #10 assisted the resident with incontinence care. However, as the resident was turned and repositioned, the bed linen under the draw sheet was observed to have a large dried yellow circle. An interview with the LPN/UM #7 conducted on June 8, 2011, at 10:25 a.m., revealed the LPN/UM conducted random checks of residents to ensure care was delivered timely. The LPN/UM further stated she probably would not have looked under the draw sheet and would have been unaware of the dried urine circle on resident #5's bed. An interview was conducted with CNA #10 on June 8, 2011, at 12:15 p.m., revealed she changed soiled linen and believed staff had time to change soiled linen when needed. An interview with the Director of Nursing (DON) on June 8, 2011, at 5:55 p.m., revealed the DON monitored staff for delivery of care but had not identified soiled linen being covered by a draw sheet.	F 315	bed linens are clean and free from dried urine circles. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance –July 22, 2011.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 332		

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F 332	<p>Continued From page 24</p> <p>review, it was determined the facility failed to ensure residents were free of medication error rates of five percent or greater. Observations of medication pass at 8:45 a.m. on June 8, 2011, revealed six medication errors occurred (residents #1, #2, and #12) with forty-nine opportunities, resulting in an error rate of twelve percent. Observation revealed two medications for resident #1 were not administered per physician's order. Further observation revealed resident #2 did not receive one medication as ordered by the physician, and resident # 12 did not receive three medications as ordered by the physician.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of medication pass at 8:45 a.m. on June 8, 2011, revealed Registered Nurse (RN) #1 administered one drop of Deep Sea Nasal Spray into each nostril of resident #1. Further observation of the medication pass revealed RN #1 crushed one Aspirin 81 milligrams (mg) Enteric Coated (EC) and administered the Aspirin EC to resident #1. <p>Record review of resident #1's June 2011 physician's order revealed an order for sprays of Deep Sea Nasal Spray to be administered in each nostril two times each day. In addition, resident #1's physician's order for Aspirin EC 81 mg stated, "Don't chew/crush-swallow whole." However, observation revealed RN #1 crushed all medications for resident #1 and administered only one spray of Deep Sea Nasal Spray.</p> <p>Interview with RN #1 at 12:25 p.m. on June 8, 2011, revealed she was aware the Aspirin EC</p>	F 332	<p><u>Tag # F 332</u></p> <ol style="list-style-type: none"> 1. Resident # 1's physician was notified on June 8, 2011 by the Unit Manager of nurse administering one spray of Deep Sea Nasal Spray for resident # 1. An order was obtained to administer another dose at that time and then continue current orders. New order was obtained for non-enteric coated Aspirin 81 mg by mouth daily for resident # 1. <p>Medication error was completed for resident # 1 related to nurse crushing enteric coated Aspirin. No adverse effect was noted related to resident being given EC Aspirin 81 mg on June 8, 2011.</p> <p>Resident # 12's physician was notified on June 8, 2011 by Unit Manager related to omission of Aspirin and Fenofibrate, and Coreg tablet. New order obtained to hold Fenofibrate x 1 day, discontinue Tricor, administer Aspirin 81 mg by mouth and Coreg 6.25 mg by mouth now. Continue all current orders. No adverse effect was noted.</p> <p>Resident # 2's physician was notified on June 8, 2011 by Unit Manager of omission of Pepcid. Order obtained to discontinue</p>	

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F 332	<p>Continued From page 25</p> <p>was not supposed to be crushed, but the resident was unable to take medication by mouth. RN #1 further stated the order was correct for resident #1 to have two sprays to each nostril of the Deep Sea Nasal Spray two times each day. RN #1 stated she/he went back to resident #1 and administered another spray to each nostril after the surveyor brought the omission to the RN's attention.</p> <p>2. Observation of medication administration conducted for resident #12 on June 8, 2011, at 9:20 a.m., revealed LPN #1 prepared 14 oral medications to be administered to resident #12. The medications were Levaquin 750 mg one tablet, Tricor 145 mg one tablet, Plavix 75 mg one tablet, Coreg 6.25 mg one tablet, Magnesium Ox 400 mg one tablet, Calcium 600 mg two tablets, Sodium Chloride one gram (one-half tablet), Doxazosin 8 mg tablet, Prostate Health one Capsule, Carafate one gram tablet, Protonix 40 mg one tablet, Lisinopril 20 mg one tablet, Reglan 10 mg one tablet, and Theophylline 300 mg one tablet. Review of the monthly physician's orders revealed resident #12 had orders for Aspirin 81 mg one tablet, Coreg 6.25 mg two tablets, and Fenofibrate 200 mg one tablet daily. Further review of resident #12's monthly physician's orders revealed Tricor 145 mg had been discontinued on June 3, 2011. Observation revealed Aspirin and Fenofibrate were omitted, and resident #12 received only one Coreg tablet.</p> <p>Interview on June 8, 2011, at 12:20 p.m., with LPN #1 revealed medications should be checked with the medication administration record to ensure residents receive the correct medication. LPN #1 stated when a nurse took an order to</p>	F 332	<p>Pepcid and continue current med orders. No adverse effect was noted.</p> <p>2. A 100 % audit of all resident MAR's, medication drawers, and MD orders will be completed by 7/1/11 by nurse management to ensure MAR's, medication drawers, and MD orders match to decrease the risk of medication errors during med pass.</p> <p>3. The SDC will complete inservice for all licensed nursing staff by 7/8/11 related to medication administration and transcription of orders.</p> <p>The DON/ADON/designee will randomly perform medication observations to ensure that medications are being administered appropriately per g-tube.</p> <p>Nurse management will review all MD orders daily (Monday through Friday) in clinical meeting to ensure correct transcription of MAR's, medications that are discontinued are removed from medication drawer to decrease the risk of medication error.</p> <p>4. An audit will be completed by nurse management team daily (Monday through Friday) x 1 week, weekly x</p>		

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F 332	<p>Continued From page 26</p> <p>discontinue a medication the medications were supposed to be removed from the resident's drawer.</p> <p>An interview conducted with the Director of Nursing (DON) on June 9, 2011, at 6:20 p.m., revealed that staff should check medications with the medication administration record to ensure residents received medications as ordered by the physician.</p> <p>3. Observation of medication administration on June 8, 2011, at 9:30 a.m., for resident #2 revealed LPN #1 prepared five medications to be administered to resident #2. The medications were Keppra 1,000 mg, Miralax 17 grams, Nystatin 5 milliliters, Senna Plus 8.6 mg one tablet, and Lopressor 25 mg. A review of the monthly physician's orders directed staff to administer Pepcid 20 mg twice daily. However, review of resident #2's current medication administration record revealed Pepcid was shown to be discontinued, and was not administered during the medication administration.</p> <p>Interview with LPN #1 on June 8, 2011, at 12:20 p.m., revealed the LPN was not aware that resident #2 was ordered to receive Pepcid. The LPN stated the medication was shown to be discontinued on the resident's current medication administration record, and the medication was not administered.</p> <p>Interview with the Director of Nursing on June 9, 2011, at 6:20 p.m., revealed managers were responsible for ensuring orders were transcribed accurately onto the medication administration record.</p>	F 332	<p>4 weeks, and monthly x 4 months to ensure MAR's, medication drawers, and physician orders match.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>	

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F 332	Continued From page 27	F 332		
F 364 SS=E	<p>Interview with the Unit Manager, LPN #2, on June 8, 2011, at 12:40 p.m., revealed Unit Managers were responsible for reviewing all monthly orders and medication administration records to ensure they were accurate, and for ensuring all new orders were on current medication administration records (MAR). Further interview revealed the UM had reviewed the monthly orders and MAR for resident #2 but did not identify that Pepcid had been discontinued from the resident's MAR.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide foods that were palatable and at a preferable temperature during the evening meal on June 7, 2011.</p> <p>The findings include:</p> <p>Observation of the evening meal service on June 7, 2011, revealed a food cart was delivered from the kitchen in a closed cart to the Rose Garden Unit of the facility at 6:05 p.m. The last tray was removed from the food cart at 6:40 p.m., 35 minutes after the food cart was delivered to the floor. A food palatability test was conducted of</p>	F 364	<p>Tag # F 364</p> <ol style="list-style-type: none"> No residents were found to have been adversely affected by this practice. All residents with oral diets have the potential to be affected. The RD inserviced the dietary manager and all dietary staff on 6/27/11 regarding correct temperature of food to be palatable and at the preferred temperature. <p>The SDC will inservice all nursing staff on or before July 8, 2011 related to time frame to serve trays and when to have trays replaced.</p> <p>Dietary staff will test and record temperature of trays with each meal prior to sending the trays to the units to be served.</p> <p>Nursing staff will serve all meal trays in 15-20 minutes after receiving them on the unit. Any tray not served in 15-20 minutes will be returned to the kitchen to be replaced with a new meal.</p> <ol style="list-style-type: none"> Dietary Manager will audit dietary staff daily (Monday through Friday) x one week, weekly x 4 weeks, and monthly x 4 months to ensure 	

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F 364	Continued From page 28 the food items from the last tray. The tray had a diet order for pureed complex carbohydrates meal. The food palatability test revealed the pureed polish sausage tasted barely warm, the mashed potatoes tasted cold, the pureed zucchini and tomatoes tasted cold, the pureed bread tasted cold, the pureed cherry cobbler tasted room temperature, and the milk tasted room temperature. An interview was conducted on June 7, 2011, at 6:45 p.m., with Licensed Practical Nurse (LPN) #5 who had been assigned to the Rose Garden Unit. The LPN stated, "I would not want my family member to eat that." The LPN further revealed 20-30 minutes was long enough for a tray to sit on the cart before it needed to be replaced. An interview was conducted on June 7, 2011, at 6:50 p.m., with State Registered Nursing Assistant (SRNA) #6, who had been assigned to provide care for the residents on the Rose Garden Unit. The SRNA stated he/she had never been told how long a tray should be allowed to sit on the food cart before it needed to be replaced due to the food items not being palatable. An interview conducted with the Dietary Manager (DM) on June 8, 2011, at 3:00 p.m., revealed the facility did not have a specific policy/procedure related to meal service. However, the DM stated food trays should be distributed within 15 minutes after the food cart had been delivered to the floor.	F 364	temperatures are being maintained during tray service. Nurse management will audit tray temperatures in regards to time daily (Monday through Friday) x one week, weekly x 4 weeks, then monthly x 4 months to ensure tray are palatable, preferred temperatures, and passed within 15-20 minutes upon delivery to units. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance –July 22, 2011.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID. PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 29</p> <p>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 - (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> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441	<p>Tag # F 441</p> <ol style="list-style-type: none"> Resident's # 25,27,28,5,29 were not found to be adversely affected by this practice. All resident's have the potential to be affected by this practice. A 100% observation will be completed by 7/15/11 by the nurse management team of meals served for handwashing guidelines, not touching food with bare hands, and when to wear gloves. The SDC will complete an inservice on or before July 8, 2011 regarding handwashing guidelines, not touching food with bare hands, and when to wear gloves. A member of the management team has been assigned to the dining rooms during meal times to oversee the meal process and observe for handwashing, use of hand sanitizer, and infection control issues. The DON or designee will complete audits daily (Monday through Friday) x one week, weekly x 4 weeks, and monthly x 4 months to ensure hands are being washing when touching or providing services for residents, not touching food with 	

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

PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
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F 441	<p>Continued From page 30</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. Staff was observed not washing/sanitizing hands during the noon and evening meal services on June 8, 2011.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Hand Hygiene, dated September 18, 2009, revealed handwashing was generally considered the most important single procedure for preventing nosocomial infections. The policy further revealed employees were expected to use handwashing, with a non-antimicrobial soap and water, or antimicrobial soap and water, if the employee's hands were visibly dirty, or were visibly soiled with blood or body fluids. The policy also revealed if hands were not visibly soiled the employee was expected to use an alcohol-based hand rub, for routinely decontaminating hands in all other clinical situations.</p> <p>Observation of the noon meal served in the Rose Garden Unit of the facility on June 8, 2011, at 12:45 p.m., revealed State Registered Nursing Assistant (SRNA) #3, while serving a lunch tray to resident #25, handled bread with his/her bare hands, and failed to don gloves. The SRNA then handed a spoon to resident #26 without washing or sanitizing his/her hands. The SRNA then assisted resident #27 with getting out of bed and into a chair. The SRNA set up the resident's tray and handled a roll with his/her bare hands without</p>	F 441	<p>bare hands, and wearing gloves when needed.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

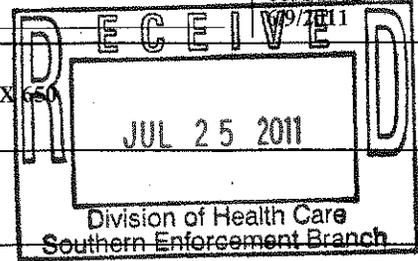
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522		
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F 441	<p>Continued From page 31</p> <p>donning gloves. The SRNA further attempted to put butter on the roll until the resident refused to have the butter. The SRNA then proceeded to serve resident #28's tray without washing or sanitizing his/her hands prior to serving. The SRNA buttered resident #28's bread, cut up the resident's meat, and failed to wash or sanitize his/her hands afterward.</p> <p>An interview conducted with SRNA #3 on June 8, 2011, at 12:50 p.m., revealed he/she should have washed his/her hands between each resident contact. The SRNA further revealed he/she should not have touched the resident's food with his/her bare hands.</p> <p>Observation of the noon meal service on June 8, 2011, at 1:05 p.m., in the large dining room of the facility, revealed SRNA #5 was feeding residents #5 and #29 at the same time. The SRNA was observed to wipe her nose with the back of her hand, and then proceeded to feed the residents without washing her hands.</p> <p>An interview conducted with SRNA #5 on June 8, 2011, at 1:10 p.m., revealed the SRNA should have washed/sanitized hands between residents, and after wiping his/her nose.</p> <p>An interview conducted with the Infection Control Nurse for the facility on June 9, 2011, at 10:30 a.m., revealed staff was expected to wash or sanitize their hands prior to feeding a resident, and after feeding a resident. The Infection Control Nurse further stated staff was also expected to wash or sanitize their hands between residents, and after touching any of their own body parts. The Infection Control Nurse further</p>	F 441		

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

PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522		
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F 441	Continued From page 32 stated the SRNA should have washed or sanitized his/her hands after wiping his/her nose. In addition, the Infection Control Nurse also stated gloves should be applied prior to touching any resident's food.	F 441			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185230	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 7/25/11
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 160	<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 a review of the facility's policy, the facility failed to convey the resident's funds, and a final accounting of those funds, to the individual or probate responsible for the resident's estate within thirty days of death for one of twenty-four sampled residents. Resident #23 expired on March 22, 2011; however, the facility failed to convey the resident's funds or account information until May 9, 2011.</p> <p>The findings include:</p> <p>A review of the Releasing Decedent Funds policy (no date) revealed funds should be released in accordance with state probate laws and health care facility regulations. There was no timeframe regarding the conveyance of the funds identified in the policy.</p> <p>A review of the financial record for resident #23 revealed the resident expired on March 22, 2011. However, there was no evidence the facility had conveyed the balance of resident #23's account to the person responsible for the resident's estate until May 9, 2011.</p> <p>An interview conducted with the Office Manager (OM) on June 9, 2011, at 4:00 p.m., revealed the resident had an "Underwriters Policy" and the facility had held the monies in resident #23's account until the resident's account balance had been paid in full. The OM stated a check was written to the resident's family on May 9, 2011.</p>		



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

The above isolated deficiencies pose no actual harm to the residents

Tag # F 160

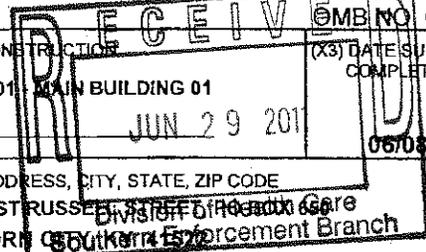
1. Resident # 23's money was refunded on 5/9/2011 as stated. Resident was not adversely affected by this practice.
2. All open accounts were pulled on 6/10/2011 by the BOM to ensure that no other decedent's funds were delayed in payment. All other funds had been sent to the resident, family, RP/POA within the 30 day timeframe.
3. The ED inserviced the BOM and AP regarding timelines of refunding decedents funds. A log will be maintained by the business office of all decedent funds with a copy of the refund check and will be discussed weekly with the ED to ensure all refunds are timely.
4. The ED will complete audits daily x one week, weekly x 4 weeks, and monthly x 4 months to ensure decedent funds are refunded within 30 days of discharge to facility.

The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.

5. Date of Compliance – July 22, 2011.

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

PRINTED: 06/23/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN, SD 57025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on June 8, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Mountain View Health Care Center was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	<u>Tag # K 029</u> 1. No residents were found to have been adversely affected by this practice. 2. The hold open device that was in use was immediately removed upon identification by the surveyor. 3. The ED will inservice all staff by June 30, 2011 regarding using non-approved hold open devices and the safety issues related to using them.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a corridor door to a hazardous area was held open in an approved manner. This deficient practice affected one of seven smoke compartments, staff, and approximately 10 residents. The facility has the capacity for 106 beds with a census of 94 on the	K 029	4. The ED/designee will complete audits daily (Monday through Friday) x one week, weekly x 4 weeks, and monthly x 4 months of all corridor doors to ensure no hold open devices are in use. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance – July 22, 2011.	

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

TITLE

(X6) DATE

Pat Adam Administrator 06-28-11

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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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522
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K 029	<p>Continued From page 1 day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on June 8, 2011, at 11:40 a.m., with the Director of Maintenance (DOM) a coridor door leading to the laundry room was observed to be held open by a hold-open mechanism on the door-closing unit. Doors to hazardous areas are not allowed to be held open in this manner. An interview with the DOM on June 8, 2011, at 11:40 a.m., revealed the DOM was not aware this was an unapproved device to hold the laundry door open.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the</p>	K 029		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 029	Continued From page 2 door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029	<p style="text-align: center;">Tag # K 038</p> <ol style="list-style-type: none"> No residents were found to have been adversely affected by this practice. New locks were purchased by the Maintenance Director and all locks were keyed to use the same key. Keys were placed at the nurses station for accessibility to the exits. The Maintenance Director inserviced all staff by June 30, 2011 regarding access and passage through exits readily accessible in a public way and placement of keys. New locks were purchased by the Maintenance Director. All locks were keyed to use the same key. A key was placed at each nurses station,, with the Maintenance Director, ED, and ER Key box. The Director of Maintenance will audit exits daily (Monday through Friday) x one week, weekly x 4 weeks, monthly x 4 months, then randomly to ensure locks remain in place and exits are readily accessible in a public way. <p>The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance</p>	
K 038 SS=E	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 readily accessible to the public way. This deficient practice affected two of seven smoke compartments, staff, and approximately 40 residents. The facility has the capacity for 106 beds with a census of 94 on the day of the survey. The findings include:	K 038		

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

PRINTED: 06/23/2011
FORM APPROVED
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K 038	<p>Continued From page 3</p> <p>During the Life Safety Code tour on June 8, 2011, at 12:10 p.m., with the Director of Maintenance (DOM) an exit leading to an enclosed courtyard was observed not to be accessible to the public way. There were two locked gates in the courtyard that would prevent occupants from reaching the public way. Keys were not readily available for staff to utilize these exits in case of fire or other emergency. An interview with the DOM on June 8, 2011, at 12:10 p.m., revealed the DOM was not aware staff did not have access to keys for the gates.</p> <p>Reference: NFPA 101 (2000 Edition). 7.7.1*</p> <p>Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.</p>	K 038	<p>Improvement Committee determines compliance.</p> <p>5. Date of Compliance – July 22, 2011.</p>	