

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

PRINTED: 08/23/2011
FORM APPROVED
OMB NO. 0938-0391

R E C E I V E D

AUG 30 2011

Division of Health Care
Surrender Enforcement Branch

08/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2011
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP+4 200 NORFLEET DRIVE SOMERSET, KY 42501
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F 000	INITIAL COMMENTS	F 000		
F 165 SS=D	<p>483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL</p> <p>A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure one of three sampled residents had a right to voice grievances without discrimination or reprisal. The facility failed to actively work toward resolution of a complaint/concern brought to their attention by a resident's family member. Resident #1's family member voiced a concern to the Unit Manager on 08/05/11, to the Administrator on 08/08/11, and to the Social Worker on 08/09/11, related to a staff member speaking rudely to the resident, not having access to the call light, and not having access to the water pitcher. There was no evidence the facility had conducted a thorough investigation regarding the family's concern/complaint.</p> <p>The findings include:</p> <p>A review of the facility's grievance policy/procedure (revised 10/09) revealed</p>	F 165	<p>F 165</p> <p>Resident # 1 and Daughter were interviewed by the RCDS on 8/10/11 and all concerns were reviewed and reported to both OIG Office of Inspector General and APS (Adult Protective Services). The facility investigated per policy, and resident and family deny any concerns as of 8/30/11.</p> <p>Administrator, Regional Director of Clinical Services, and Director of Nursing to review grievances for the period of 7/1/2011 thru August 30, 2011. We will identify any grievance that has not been addressed or reviewed per policy. Any grievance issues with follow-up will be addressed per policy/procedure by 9/2/2011 by the Administrator, RDCS, and DON.</p> <p>Education and Training Director to re-educate all staff regarding the policy/procedure on filing a grievance and also the policy/procedure on abuse and neglect by 9/3/2011.</p> <p>The RCDS will re-educate Administrator and DON regarding the policy/procedures on grievances and abuse and neglect by 9/1/2011</p> <p>QA committee to audit findings at least monthly to review and revise our plan as needed beginning 9/1/2011.</p> <p>Date of Compliance: 9/4/2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gil Spurgeon</i>	TITLE <i>Admin</i>	(X8) DATE 8/30/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Aug. 30, 2011 4:54PM No. 1860

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F 165	<p>Continued From page 1</p> <p>residents and family members have the right to express their grievances or concerns directly to Administration without fear of discrimination or reprisal. The policy further stated any employee may initiate a "Resident Concern Report" (RCR) for any and all concerns. Once the Resident Concern Report is initiated, it was to be submitted to the Administrator. The Administrator was to read the RCR during the Daily Stand-Up Meeting, determine which Department the concern was focused on, and give the RCR to that Department for resolution. According to the policy, the identified Department was to communicate with the resident/family and attempt to resolve the issue within five days, to complete the second page of the RCR, which is the details of the investigation as well as the resolution to the grievance, and to bring the RCR back to the Daily Stand-Up Meeting and give the report to the Social Worker. The Administrator was to then follow up with the resident/family about the concern to ascertain satisfaction with the resolution of the reported concern.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 08/04/11, with diagnoses of Diabetes, Urinary Retention, Pressure Ulcer, Crohn's Disease, Small Bowel Perforation/Peritonitis with Small Bowel Resection, and Ileostomy.</p> <p>A review of the RCR initiated on 08/05/11, revealed Resident #1's family member had voiced concerns to the Unit Manager (UM) that a staff member had been rude to the resident. According to the RCR, the UM talked to the resident, who was unable to give the name of the staff person who had been rude to the resident.</p>	F 165		

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F 165	<p>Continued From page 2</p> <p>According to documentation by the UM, the resident described the staff person to the UM and the UM noted she was "presently looking at schedules and talking to staff." There was no documentation on the RCR that the facility had acted on the resident's complaint at that time.</p> <p>A review of the RCR dated 08/08/11, initiated by the Facility Administrator stated Resident #1's family member had concerns about the resident being unable to reach the call light or water pitcher, that a staff person was "short" with the resident, and the resident was left "wet" for long periods. The investigation section of the RCR revealed, "Investigation already started from 8/5," "narrowed it down to one or two aides on the night shift," and "one of the CNA's was reassigned pending our investigation." No other documented evidence of investigations or interviews was available.</p> <p>A review of the RCR dated 08/09/11, revealed Resident #1's daughter had also told the Social Worker (SW) she was concerned that the call bell/water pitcher was out of the resident's reach and that a staff member had been rude to the resident. The investigation section of the RCR revealed the investigation was "ongoing" and the complaint had already been reported on 08/05/11.</p> <p>A tour of the facility conducted on 08/10/11, at 6:00 AM, revealed residents' water pitchers/call lights were within reach and interviews conducted on 08/10/11, with Resident #2 at 8:30 AM, and Resident #3 at 1:15 PM, revealed staff was responsive and respectful to residents.</p> <p>Observations of Resident #1 on 08/10/11, at 5:45</p>	F 165		

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F 165	<p>Continued From page 3</p> <p>AM and 9:25 AM in the resident's room, at 2:00 PM in the Physical Therapy Department, and 3:10 PM in the beauty salon, revealed the resident was alert, oriented, and pleasant. Interviews during these times revealed the resident to be oriented and in pleasant spirits.</p> <p>An interview with Resident #1 at 3:40 PM on 08/10/11, in the resident's room revealed a staff member on the night shift was "rude" to the resident. Resident #1 stated, "She (the staff person) jerked me and I told her not to do that." Resident #1 further stated the staff person spoke in a rough tone. According to the resident, he/she did not report this to facility staff, but did tell her/his family member.</p> <p>A telephone interview with Resident #1's family member on 08/09/11, at 4:00 PM, revealed she had spoken with the Unit Manager (UM) on 08/05/11, concerning the night shift staff person who was rude to the resident. The resident's family member stated the staff person was not abusive, but was rude, and spoke in a rough tone to the resident. The family member also stated she had spoken to the Facility Administrator (FA) and the Social Worker (SW) on 08/09/11, regarding the resident's call light not within the resident's reach and not having access to a water pitcher in addition to the concerns she had voiced to the UM four days before concerning the staff member's rude behavior. Resident #1's daughter stated the Administrator appeared to be distracted and not interested in her concerns. The daughter further stated no one had discussed with her how the facility would attempt to resolve any of her concerns.</p>	F 165			

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F 165	<p>Continued From page 4</p> <p>An interview with the Unit Manager on 08/10/11, at 2:30 PM, revealed Resident #1's family member had spoken to the UM on 08/05/11, and reported that a staff member had been rude to the resident. The UM stated she initiated a RCR and reported the concern to the Director of Nursing (DON) and the FA.</p> <p>An interview with the Social Worker (SW) on 08/10/11, at 2:20 PM, confirmed the SW had also received a complaint from Resident #1's daughter on 08/09/11, related to the call bell and water pitcher out of the resident's reach and that a staff member had been rude to the resident. The SW stated she initiated the RCR form and submitted it to the FA on 08/09/11.</p> <p>An interview with the FA on 08/10/11, at 2:50 PM, revealed the FA had received a report regarding the concern voiced by Resident #1's family member that an employee had been rude to Resident #1. The FA stated the Director of Nursing (DON) and the UM were conducting an investigation into the complaint. The FA also stated the family member came to the FA's office on Monday, 08/08/11, to voice concerns related to a staff member being rude to the resident. In addition, the family member reported the resident's call light and water pitcher were not within the resident's reach and the resident was "wet" for a long time. The FA stated she also initiated a RCR regarding Resident #1's daughter's concern.</p> <p>An interview was conducted with the FA, DON, and Regional Nurse Consultant on 08/10/11, at 4:30 PM. The DON stated she had talked to Resident #1's daughter a few times but did not</p>	F 165		

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F 166	Continued From page 5 document any information. There was no evidence the facility conducted a thorough investigation into the concerns voiced by Resident #1's daughter or attempted to resolve the complaints voiced.	F 165		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission 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.	F 441	F441 1. Resident # 1 MD was made aware that the nurse did not wash her hands at least one time during the wound care to her coccyx. No new orders were noted. 2. The Education and Training Director/ Unit Manager to audit at least 6 nurses providing wound care, including the Wound Care Nurse to identify if the policy/procedures for hand washing is followed by 9/2/11. 3. The ETD to re-educate the nursing staff regarding the policy/procedures for hand washing, concentrating on hand washing during wound care, by 9/2/2011. 4. The Quality Assurance committee will meet at least monthly to audit our findings and review/revise the plan as needed beginning 9/1/2011. Date of Compliance: 9/4/2011	

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F 441	<p>Continued From page 6</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 by: Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were maintained for one of three sampled residents. During wound care for Resident #1, the treatment nurse failed to utilize acceptable handwashing technique when performing wound care to the resident's coccyx.</p> <p>The findings include:</p> <p>A review of the facility's Hand Hygiene Policy revealed staff was to wash/sanitize their hands after contact with non-intact skin and wound dressings. An interview with the Regional Nurse Consultant (RNC) on 08/10/11, at 4:30 PM, revealed the facility does not have a "wound care" policy and that staff was to follow MD orders.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted Resident #1 on 08/04/11, with diagnoses of Diabetes, Urinary Retention, Pressure Ulcer, Crohn's Disease, Small Bowel Perforation/Peritonitis with Small Bowel Resection, and Ileostomy. Further review of the clinical record revealed on 08/05/11, Resident #1's physician had ordered staff to cleanse the pressure ulcer on the resident's coccyx with normal saline, apply Santyl ointment,</p>	F 441		

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F 441	<p>Continued From page 7 and apply a clean dry dressing.</p> <p>Observation of wound care on 08/10/11, at 9:25 AM, revealed the Wound Care Nurse (WCN) washed her hands, put on non-sterile gloves, removed the soiled dressing from the resident's coccyx, and cleansed the wound with saline soaked gauze. The WCN then removed the soiled gloves and put on new gloves. However, the WCN failed to wash her hands prior to putting on the clean gloves.</p> <p>An interview with the WCN at 10:25 AM on 08/10/11, revealed the WCN was aware she should have washed her hands after removing soiled gloves. The WCN stated she "just forgot."</p> <p>An interview with the Staff Development Nurse (SDC) on 08/10/11, at 2:10 PM, revealed the facility conducted clinical skills check assessments of all clinical staff during orientation and yearly thereafter. The SDC stated she had not identified concerns related to the WCN's technique during the assessment of her skills.</p>	F 441			