

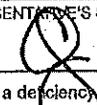
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2012
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NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 252 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An annual recertification survey and abbreviated survey (KY #18860) was conducted on 08/05/12 through 08/07/12 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "E". KY #18860 was substantiated with deficiencies cited.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable and homelike environment related to strong urine odors on the South Hall as well as residents' bathrooms. The exact source of the urine odor was not determined, and the urine odor was present throughout the date of the survey, 08/05/12 through 08/07/12.</p> <p>Findings include: On 08/05/12 at 10:10 AM, a tour of the South Hall revealed an overwhelming urine odor that was concentrated in the middle section of the hall area. The urine odor was present at 3:00 PM and at 5:30 PM as supper trays were being distributed to some of the rooms on that hall. On 08/06/12 at</p>	<p>F 000</p> <p>F 252</p>	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F252 Completion Date 09/10/12</p> <p>The odor was identified on the middle section of the south hall by the Housekeeping Supervisor. The Housekeeping Supervisor applied a neutralizer to the resident room and bathrooms floors in room 132 on 8/8/12 and in rooms 101, 103, 110, 112 on 8/8/12.</p>	<p></p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/30/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	<p>Continued From page 1</p> <p>8:30 AM, during the breakfast meal on the South Hall, there was an overwhelming urine odor along the middle section of the hall. On 08/07/12 at 12:30 PM, the strong urine odor was evident on the middle section of the South Hall.</p> <p>Additionally, observation on 08/05/12 at 10:30 AM and 11:30 AM, on 08/06/12 at 8:30 AM, 9:30 AM, and 10:30 AM, and on 08/07/12 at 8:30 AM and 10:30 AM, revealed there was a strong urine odor in the bathroom of Room #101, #103, #110, and #112.</p> <p>An interview with Certified Nurse Aide (CNA) #3, on 08/07/12 at 3:15 PM, revealed she thought the urine odor was from residents in one of the rooms as well as the linen carts that were usually parked on the hall. She stated the linen carts were changed out at the end of each shift.</p> <p>An interview with the Housekeeping Supervisor, on 08/07/12 at 1:10 PM, revealed she thought the urine odor was between Room #132 and Room #135, and at one time thought it was the trash. The trash is now picked up more frequently; however, the urine odor has remained. She was unable to determine the source of the urine odor. Further interview with the Housekeeping Supervisor, at 2:00 PM, revealed the housekeepers began work at 6:30 AM in the morning. They cleaned the general or "visual" areas first and then cleaned the residents' bathrooms. She stated the urine odor in those bathrooms was "strong" first thing in the morning.</p> <p>An interview with the Administrator, on 08/07/12 at 1:15 PM, revealed she was unsure of the origin of the urine odor. No further explanation was</p>	F 252	<p>The Housekeeping Supervisor and Administrator made rounds throughout the facility on 8/22/12 to identify specific resident rooms or locations of urine odors and assess for a safe, clean, comfortable and homelike environment. Neutralizing the resident and bathroom floors were effective, no other areas were identified.</p> <p>The Housekeeping Supervisor was re-educated on 8/22/12 by the Administrator regarding providing a clean, comfortable environment specific to the cause of odors and how to reduce and/or eliminate odors. The Director of Nursing re-educated nursing staff on providing a clean, safe, comfortable environment including the management of soiled linen and trash to eliminate and manage odors on 8/23/12. The neutralization of the identified resident rooms will continue as needed.</p>		

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F 252	Continued From page 2 provided.	F 252	The Housekeeping Supervisor, and/or Director of Nursing and/or Assistant Director of Nursing and Administrator will make daily rounds five times per week for four weeks, then three times per week for four weeks, then two times per week for four weeks to identify potential problems that may cause odors in the facility. Identified problems will be corrected and addressed immediately. The Administrator will report finding to the Performance Improvement Committee monthly for three months, attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations.	09/10/12	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to follow the comprehensive nursing care plan related to improper control settings on the Care Guard Alternating Pressure Pump Air Mattress for one resident (#8), in the selected sample of 16 residents. Observations during the survey revealed settings on the Care Guard Alternating Pressure Pump Air Mattress were set on number	F 279			
			Resident #8's Care Guard Alternating Pressure Pump Air Mattress was validated set on 4.5 by the Director of Nursing on 8/7/12. The Alternating Pressure Pump was labeled with the appropriate settings on 8/7/12 by the Administrator.		

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F 279	<p>Continued From page 3</p> <p>2; however, the resident was care planned for the setting to be on number 4.5.</p> <p>Findings include:</p> <p>A review of the facility's Care Plan Interdisciplinary Policy and Procedure, dated 01/08, revealed, "It is the policy of the center to develop an individualized plan of care for each resident utilizing the information gathered during each assessment." The policy and procedure did not address how to follow the comprehensive nursing care plan.</p> <p>A review of the Care Guard Alternating Pressure Pump Model # CG 9701 assembly, installation and operating instructions, revised 7/98, revealed no specific instructions about adjusting the settings of the mattress control.</p> <p>A record review revealed the facility admitted Resident #8 on 06/30/10 with diagnoses to include Difficulty Walking, Muscle Weakness, Alzheimer's Disease, After Care Healing Traumatic Fracture Vertebrae, and Diabetes Type II. A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/21/12, revealed the facility assessed the resident to be moderately cognitively impaired.</p> <p>A review of the physician's order, dated 01/26/12, revealed "alternating pressure pump pad mattress settings at 4.5, check settings and placement every shift - every shift everyday."</p> <p>A review of the Comprehensive Nursing Care Plan, dated 02/23/12, revealed alternating pressure pump mattress to the bed with settings</p>	F 279	<p>Current residents care plans were reviewed by the Director of Nursing for interventions to maintain the residents' highest practicable physical, mental and psychosocial well-being with compliance by staff and specific attention to Alternating Pressure Pump Air Mattresses on 8/7/12. Care plan updates were completed as indicated.</p> <p>Nursing staff were re-educated pertaining to following the comprehensive care plans and monitoring settings on Alternating Pressure Pump/Low Air Loss Mattresses by the Director of Nursing and Assistant Director of Nursing on 8/23/12. Residents with Alternating Pressure Pump Air Mattresses/Low Air Loss Pump Mattresses were labeled with appropriate settings on 8/7/12 by the Administrator.</p>	

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F 279	Continued From page 4 on 4.5. A review of the MDS Kardex Report and the Treatment Administration Record, both dated August 2012, revealed "Alternating Pressure Pump air pad to mattress, settings at 4.5, check settings and placement every shift everyday." Observation, on 08/05/12 at 11:30 AM, and on 08/06/12 at 9:35 AM, 11:15 AM, 1:05 PM, and 2:30 PM, revealed Resident #8 was lying in bed with the Care Guard Alternating Pressure Pump setting at 2. An interview with Registered Nurse (RN) #2, on 08/07/12 at 5:35 PM, revealed "I usually check [his/her] air mattress settings when I do my second accu-checks, but I would have to refer to the Treatment Administration Record. I am not sure what [his/her] settings should be, and I'm not sure why it would be on another setting." An interview with the Director of Nursing (DON), on 08/07/12 at 4:30 PM, revealed nursing was responsible to ensure the bed was on the correct setting. The DON was unsure if nurses documented that they checked the setting on the alternating air mattress.	F 279	The Director of Nursing, Assistant Director of Nursing or Unit Manager will review four care plans with Alternating Pressure Pump Air Mattresses two times per day for five days, then two times per week for three weeks, then weekly for two months. The Director of Nursing will report findings to the Performance Improvement Committee for three months, attended by the Medical Director, Administrator, Director of Nursing and the Interdisciplinary Team Members for further recommendations.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	Resident #4's device assessment, care plan, CNA care card, physician orders and family notification were completed on 8/7/12 by the Unit Manager. Occupational Therapy was ordered to evaluate and treat for continuation or modification of assistive devices on 8/7/12. Current residents care plans were reviewed revised and updated to	F280 Completion Date 09/10/12	

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F 280	<p>Continued From page 5</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to assess for an assistive positioning device for one resident (#4), in the selected sample of 16 residents. Resident #4 sustained a fall from the bed causing bruising and a skin tear. The facility's investigation determined the root cause of the fall was an improperly placed wedge cushion for positioning. The facility failed to assess for the use of the positioning wedge and there was no care plan to address the use of the positioning wedge.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, Care Plan-Interdisciplinary, dated 01/08, revealed "It is the policy of the center to develop an individualized plan of care for each resident utilizing the information gathered during each</p>	F 280	<p>reflect current resident status and assistive devices on 8/7/12 by the Assistant Director of Nursing, Unit Manager and Charge Nurse. Resident care plans are reviewed at a minimum quarterly by the Interdisciplinary Team to ensure they meet the needs of the resident. Licensed nurses were re-educated pertaining to the process for initiating assistive and restrictive devices and revising/updating the care plan with changes in condition or treatments by the Assistant Director of Nursing on 8/23/12.</p> <p>The Director of Nursing, Assistant Director of Nursing or Administrator will review five random residents for appropriate assessment of assistive devices and updated care plans that reflect current resident status for five days, then weekly for three weeks and then monthly for two months. The Director of Nursing will report the findings to the Performance Improvement Committee for three months, attended by the by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations.</p>		

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F 280	<p>Continued From page 6 assessment."</p> <p>A review of the facility's policy/procedure, "Assessment, Identifying Residents in Need of Devices," dated 01/08, revealed "Responsible parties: Licensed Nurse, Interdisciplinary Team, Physician, Resident and Family. Time frame: before and during the admission process; daily, weekly, and quarterly according to the MDS assessment schedule; PRN (as needed), as indicated." The policy/procedure also included devices can be categorized as follows: "assistive, lap tray, self-release seat belt, positioning device as wedges, and bolsters."</p> <p>A record review revealed the facility admitted Resident #4 on 10/01/08 with diagnoses to include Bipolar Disease, Unspecified Psychosis, Paralysis Agitans, Chronic Kidney Disease, Congestive Heart Failure, Dementia, Dysphagia Oral Phase, and Morbid Obesity. Review of a falls assessment, dated 05/22/12, revealed the resident was at risk for falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/22/12, revealed the resident was severely cognitively impaired, was non-ambulatory and required extensive assistance with all activities of daily living.</p> <p>A review of a Change of Condition form, dated 07/26/12 at 6:55 AM, revealed Registered Nurse (RN) #1 documented Resident #4 was found on the floor on his/her right side with his/her head resting on the oxygen concentrator. A raised area and a skin tear were noted on the temple region. The physician and family were notified and the resident was transferred to the emergency room for an evaluation and treatment.</p>	F 280		

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F 280	Continued From page 7 An observation, on 08/05/12 at 10:20 AM, revealed Resident #4 was in bed with his/her eyes closed. Bruising was observed on most of the resident's face, and on his/her bilateral arms. The resident did not respond when spoken to. Further record review revealed there was no evidence of an assessment for the use of a wedge for positioning. There was no care plan intervention for the use of a wedge for positioning and no indication when or who implemented the wedge for positioning. An interview with the Director of Nursing (DON), on 08/06/12 at 2:15 PM, revealed there was no assessment for the positioning wedge and nurses should have assessed for the use of a positioning wedge. Additionally, she revealed there was no care plan intervention to address the use of the positioning device.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the	F 323	F323 Completion Date Resident #4's device assessment, care plan, CNA care card, physician's orders and family notification were completed on 8/7/12 by the Unit Manager. Occupational Therapy was ordered to evaluate and treat for continuation or modification of assistive devices on 8/7/12. Current residents were reviewed for assistive/restrictive devices and reassessments were completed for appropriateness by the Assistant Director of Nursing, Unit Manager and Charge Nurse on 8/7/12. Care plans were updated as indicated.	09/10/12

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F 323	<p>Continued From page 8</p> <p>resident's environment remained free from accident hazards as is possible for one resident (#4), in the selected sample of 16 residents. Resident #4 sustained a fall from the bed on 07/26/12 and was transferred to the emergency room for an evaluation and treatment. The facility determined the root cause of the fall was an improperly placed wedge that was used for positioning. Resident #4 had not been assessed for the use of a wedge for positioning and there was no care plan intervention to address the wedge as a positioning device.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, Accidents/Incidents (policy number CL-676-0001), dated 01/08, revealed responsible parties as the Licensed Nurse, Interdisciplinary Team (IDT), Director of Nursing (DON), and Administrator. The policy statement included "It is the center's policy to provide an environment that is free from hazards over which the center has control. The intent of this policy is that the center identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents."</p> <p>A review of the facility's policy/procedure, "Assessment, Identifying Residents in Need of Devices," dated 01/08, revealed "Responsible parties: Licensed Nurse, Interdisciplinary Team, Physician, Resident and Family. Time frame: before and during the admission process; daily, weekly, and quarterly according to the MDS assessment schedule; PRN (as needed), as indicated." The policy/procedure also included</p>	F 323	<p>Midnight nurse aides were re-educated by the Director of Nursing and LPN Charge Nurse on correct positioning of wedge cushion on 7/26/12. Nursing staff were re-educated with return demonstration competency on use of wedge cushions by the Assistant Director of Nursing on 8/23/12.</p> <p>Licensed nurses were re-educated pertaining to process for initiating assistive and restrictive device assessments by the Assistant Director of Nursing on 8/23/12.</p> <p>The Director of Nursing, Assistant Director of Nursing and/or Administrator will audit five residents with wedge type cushions for appropriate placement daily, at varying times for five days, and three per week for three weeks, then four per month for two months. The Director of Nursing will report findings to the Performance Improvement Committee for three months, attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations.</p>		

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F 323	<p>Continued From page 9</p> <p>devices can be categorized as follows: "assistive, lap tray, self-release seat belt, positioning device as wedges, and bolsters."</p> <p>A record review revealed the facility admitted Resident #4 on 10/01/06 with diagnoses to include Bipolar Disease, Unspecified Psychosis, Paralysis Agitans, Chronic Kidney Disease, Congestive Heart Failure, Dementia, Dysphagia Oral Phase, and Morbid Obesity. Review of a falls assessment, dated 05/22/12, revealed the resident was at risk for falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/22/12, revealed the resident was severely cognitively impaired, was non-ambulatory and required extensive assistance with all activities of daily living.</p> <p>A review of the Fall Event, dated 07/26/12, revealed a fall occurred at 6:55 AM and the resident sustained a "head injury." Staff responded after hearing the resident yelling out and found him/her laying on the floor beside the bed with his/her head against the oxygen concentrator. Resident #4 was assessed by the nurse, neuro checks were within normal limits and he/she complained of his/her head hurting. The Fall Event listed the cause of the fall as staff handling and "had a wedge cushion, midnight staff did not place appropriately" and was too close to the side of the bed. The fall investigation revealed the fall was related to positioning and that the resident was positioned too close to the edge of the bed and turned on his/her side too far.</p> <p>A review of a Change of Condition form, dated 07/26/12 at 6:55 AM, revealed Registered Nurse</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>(RN) #1 documented Resident #4 was found on the floor on his/her right side with his/her head resting on the oxygen concentrator. A raised area and a skin tear were noted on the temple region. The resident voiced a complaint that his/her head hurting. The physclan and family were notified and the resident was transferred to the emergency room for an evaluation and treatment.</p> <p>An observation, on 08/05/12 at 10:20 AM, revealed Resident #4 was in bed with his/her eyes closed. Bruising was observed on most of the resident's face, and present on his/her bilateral arms. The resident did not respond when spoken to.</p> <p>Further record review revealed there was no evidence of an assessment for the use of a wedge for positioning. There was no care plan Intervention for the use of a wedge for positioning and no indication when or who implemented the wedge for positioning.</p> <p>An interview with RN #1 on 08/05/12 at 2:00 PM revealed on 07/26/12, he heard Resident #4 yelling and found him/her in the floor by the bed with his/her head resting on the oxygen concentrator. The resident had a skin tear near his/her eye and was sent out to the emergency room. RN #1 revealed the resident had a new wedge to assist positioning from side to side and felt the wedge, which was large, may have contributed to the fall.</p> <p>An interview with the Director of Nursing (DON), on 08/06/12 at 8:45 AM and 2:15 PM, revealed no statements were obtained related to the fall</p>	F 323			

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F 323	Continued From page 11 Investigation and the root cause of the fall was that the wedge was improperly placed. She revealed there was no assessment for the positioning wedge and nurses should have assessed for the use of the wedge. Additionally, there was no care plan intervention to address the use of the positioning device.	F 323			
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's definition for Puree Texture, it was determined the facility failed to ensure one resident (#4), in the selected sample of 16 residents, received food in a form to meet their individual needs. Resident #4, whose diet was down-graded to a pureed diet on 08/03/12, was observed, on 08/05/12, to be fed chopped roast beef instead of pureed roast beef. Findings include: A review of the facility's definition for Puree Texture, undated, included "Pureed Texture: This is the first consistency allowed after NPO and liquid diets. Chewing to masticate food in the mouth is completely eliminated. All foods are pureed, blenderized or strained to ensure a smooth, cohesive quality without lumps. (Adapted from the National Dysphagia Diet (NDD, Level 1). This diet may be appropriate for	F 365 <u>F365</u>	Resident #4's dietary tray card was updated to reflect the appropriate diet on 8/7/12 by the Dietary Manager. The Dietary Manager re-educated the dietary staff on processing dietary communication related to making diet changes to tray cards in the kitchen if the Dietary Manager is absent on 8/5/12. CNA #1 was re-educated by the Director of Nursing Services on the process of reviewing nurse aide care cards/tray cards to serve the appropriate diet consistency to residents on 8/13/12. Occupational Therapy was ordered to evaluate and		09/10/12

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F 365	<p>Continued From page 12 conditions related to oral health/dentition or dysphasia management."</p> <p>A record review revealed the facility admitted Resident #4 on 10/01/06 with diagnoses to include Bipolar Disease, Unspecified Psychosis, Paralysis Agitans, Chronic Kidney Disease, Congestive Heart Failure, Dementia, Dysphagia Oral Phase, and Morbid Obesity. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/22/12, revealed the resident was severely cognitively impaired, had coughing or choking during meals or when swallowing medications and required extensive assistance from the staff.</p> <p>An observation, on 08/05/12 at 12:30 PM, revealed Resident #4 was in his/her room in bed, being fed chopped roast beef. Pureed carrots, thickened liquids were observed on the resident's food tray in regular glasses. Empty assistive drinking cups were laying on their sides on the food tray. Observation of the dietary card revealed his/her diet was pureed with ground meat with no added salt.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 08/05/12 at 12:30 PM, revealed Resident #4 was a "feeder." CNA #1 stated the assistive cups did not work very well when liquids were thickened. The CNA also stated the resident would eat well at times and not others.</p> <p>An interview with the Regional Registered Dietician and the Dietary Manager, on 08/07/12 at 12:45 PM, revealed Resident #4's diet was downgraded to pureed on 08/03/12, late in the day. The Licensed Nurse or Therapy made the</p>	F 365	<p>treat for continuation or modification of assistive devices on 8/7/12.</p> <p>Current resident diets were reviewed by the Dietary Manager to ensure that the physician orders correlated with the dietary tray card system and validation completed by the Director of Nursing on 8/6/12. There were no concerns noted at that time.</p> <p>The Assistant Director of Nursing and Dietary Manager re-educated nursing staff and dietary staff to ensure that the residents receive and consume food in the appropriate form and the appropriate nutrient content as prescribed by the Physician. Staff was also re-educated to ensure that likes and dislikes are followed. Re-education was completed on 8/5/12 by the Assistant Director of Nursing and 8/5/12 through 8/7/12 by the Dietary Manager. The Dietary Manager re-educated the dietary staff on processing dietary communications related to making diet changes to tray cards in the kitchen in the event the Dietary Manager is absent on 8/5/12.</p>		

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F 365	Continued From page 13 dietary changes. A communication sheet was sent to the Dietary Department on 08/03/12 with the new order for House Carbohydrate Consistent, No added Salt, Pureed Consistency and Nectar thick liquids. The resident's dietary card was suppose to be changed in the computer. The Dietary Manager was the only staff that could make the change to the dietary card in the computer for the diet card print out. Staff usually marked on the dietary card when there was a change the Dietary Manager could not immediately change in the computer. Resident #4's dietary card did not get changed until 08/07/12 by the Dietary Manager. An interview with the Speech Language Pathologist, on 08/07/12 at 1:45 PM, revealed she educated the staff related to supervision of Resident #4 due to being a poor eater and who had several previous choking episodes. She stated a resident who received a pureed diet would be at an increased risk for choking if being fed ground meat instead of pureed meat. An interview with the Director of Nursing (DON), on 08/07/12 at 1:30 PM, revealed she was unaware Resident #4 had received ground meat instead of the ordered pureed diet. She additionally stated a potential problem was that the resident could become choked.	F 365	The Dietary Manager and/or Registered Dietitian and/or licensed nurse and/or weekend administration staff, will audit ten trays daily for two meals for fourteen days and then ten trays daily for one meal for fourteen days, then ten trays daily for one meal twice a week for four weeks. The Dietary Manager will report findings to the Performance Improvement Committee for two months, attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371			

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F 371	Continued From page 14 under sanitary conditions This REQUIREMENT Is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was stored and distributed under sanitary conditions. Observation, on 08/05/12, revealed numerous items in the refrigerators that had no open or preparation date on them. The milk cooler had standing water in the bottom and brooms and mops were observed sitting directly on the floor. Mouse droppings were observed on multiple areas of the kitchen floor. Findings include: On 08/05/12 at 10:30 AM, observation in the kitchen revealed numerous items stored in the refrigerators to include: four opened gallons of milk, two individual containers of tuna salad, a plate with sliced tomatoes and a container of orange juice all unlabeled and undated. Additionally, containers of food were observed including a container of cooked chicken with a date of 07/28/12, a container of house apple sauce dated 07/03/12, Salisbury steak dated 07/30/12, and a container of chicken and dumplings dated 07/31/12. An additional observation, on 08/07/12 at 10:10 AM, revealed a container labeled bacon grease had a date of 07/01/12. Interview with the Dietary Manager, at the time of	F 371	<u>F371</u> Completion Date All unlabeled items and containers of food dated greater than seven days were disposed of immediately on 8/5/12 by the Dietary Manager. Left over food will be stored no more than seven days in the refrigerator per company policy. Staff was re-educated regarding labeling and dating all foods by the Dietary Manager on 8/5/12. Squeegee and broom were immediately placed on wall racks on 8/5/12 by the Dietary Manager. The milk box was immediately emptied, drained and cleaned on 8/5/12 by the Dietary Manager. The cleaning schedule was updated to ensure milk box cleaning was done twice per week by the Dietary Manager. Mouse droppings were disposed of immediately from area on 8/5/12 by the Dietary Manager.	09/10/12	

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F 371	Continued From page 15 observation on 08/05/12 at 10:35 AM, revealed leftover food was only to be kept for three days and all items in the refrigerators was to be labeled and dated. Observation, on 08/05/12 at 10:40 AM, revealed a broom and floor squeegee sitting directly on the floor instead of hanging in the appropriate holders. Also, observation of the milk cooler revealed standing water in the bottom and there was a sour odor. On 08/05/12 at 11:10 AM, observation revealed mouse droppings on the floor under the three compartment sink, under the freezer door, under the dish wash counter and under a rolling preparation table. Two live catch mouse traps were observed under the counters. An interview, on 08/07/12 at 10:30 AM, with the facility Registered Dietician (RD) revealed all leftover food items should be labeled and dated but was not sure how long left over food should be stored in the refrigerator. The RD also stated she was not aware of a mouse problem in the facility kitchen and any droppings should have been cleaned up immediately.	F 371	The Dietary Manager audited the kitchen area for storing and distribution of food under sanitary conditions on 8/7/12. The review included the coolers/freezers for open foods, labels and dates, cleanliness of milk box, storage of cleaning supplies and floor maintenance. Identified concerns were addressed at that time. The Dietary Manager was re-educated by the Administrator and Regional Registered Dietician on 8/5/12 to ensure food is stored and served under sanitary conditions including; labeling and dating open foods, policy regarding time frames for open foods requiring refrigeration and the appropriate storage of cleaning equipment. Cleaning schedules completed daily, including but not limited to sweeping under and behind all equipment. Dietary staff were re-educated on labeling and dating of foods, storage of cleaning supplies and updated cleaning schedule and cleaning process by the Dietary Manager on 8/5/12 through 8/7/12.		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469			

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F 469	<p>Continued From page 16</p> <p>Based on observation, interview, and review of the facility's pest control contract/service agreement, it was determined the facility failed to have an effective pest control program to ensure the facility was free of pests and rodents. Observations on 08/05/12, 08/06/12, and on 08/07/12, revealed multiple areas of the facility with multiple flies crawling on residents, on food plates and crawling on residents' beds. Additionally, mice droppings were observed on the floor in multiple areas of the kitchen.</p> <p>Findings include:</p> <p>Observation on 08/05/12, 08/06/12 and 08/07/12, revealed flies were flying around on the South and North Halls and in residents' rooms. Additionally, flies were observed all three days in the dining room. A fly swatter was observed hanging by the North Hall nursing station.</p> <p>Observation, on 08/05/12 at 3:25 PM, revealed Resident #4 was in the bed and a fly was flying around his/her face. Resident #4 stated there "was at least one fly all the time" in the room. Flies were also noted flying around outside the resident's door. A fly swatter was observed laying on the resident's bed side table.</p> <p>Observation and interview with Resident #6, on 08/07/12 at 12:30 PM, revealed the resident was eating his/her noon meal and a fly was observed to be sitting on the resident's macaroni and cheese. The resident waved the fly away and stated "I do not like fly's around my food." The resident further stated, "the flies were bad in the facility a few days ago."</p>	F 469	<p>The Dietary Manager or weekend manager will audit the milk box cleaning and kitchen cleaning schedules, the mop and broom storage, labeling and dating of opened and refrigerated foods daily for fourteen days, then three times per week for four weeks, then monthly for three months. The Dietary Manager will report the findings to the Performance Improvement Committee monthly for five months, attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations.</p> <p><u>F469</u> Completion Date 09/10/12</p> <p>A new air curtain was ordered and installed above the door going out to the garden on 8/29/12 by the Maintenance Director. The existing air curtain was installed above the door going out the dining room door on 8/29/12 by the Maintenance Director. The Ecolab pest controller completed an on-site visit on 8/9/12 and will continue monthly visits and as indicated. Approved fly traps were placed in resident rooms as needed with their approval on 8/27/12. The</p>		

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F 469	<p>Continued From page 17</p> <p>Interview with Resident #8, on 08/06/12 at 8:55 AM, revealed "I'm really concerned about the flies, when I'm trying to eat they fly right in my eye's, they land on my food and my plate. I don't think that's too healthy." The resident further stated, "They have been here ever since I've been here, they have multiplied, started out with one or two, now there's a lot, they have hatched."</p> <p>Observation, on 08/07/12 at 1:20 PM, revealed, while conducting an interview with Resident #13, a fly landed on the grapes that Resident #13 was eating.</p> <p>On 08/05/12 at 5:10 PM, the Housekeeping Supervisor was observed walking up and down the hall areas with a fly swatter and swatting at flies. Interview with the Housekeeping Supervisor revealed she was instructed to walk around the facility with a fly swatter to kill flies.</p> <p>On 08/06/12 at 9:50 AM, during an observation of a medication pass, flies were noted to be crawling on the medication cart and Licensed Practical Nurse (LPN) #2, who was administering medications, repeatedly swatted at the flies. LPN #2 stated that flies had been a problem for a couple of weeks.</p> <p>Review of the facility pest control contract/service agreement revealed the pest control service did an on-site visit monthly. Glue boards were in place in three areas of the facility for capturing flies and the glue board was changed monthly. There were no additional on-site visits to treat the fly problem.</p> <p>An interview, on 08/07/12 at 2:45 PM, with the</p>	F 469	<p>mouse droppings were removed by the Dietary Manager on 8/5/12.</p> <p>The facility was audited for fly control and mice droppings by the Administrator and Maintenance Director on 8/22/12. Flies were minimal, no mice droppings noted. No other issues identified.</p> <p>The Administrator and/or Maintenance Director audit the facility for flies and signs of mice daily five times per week then two times per week for three weeks, then monthly for two months. The Administrator will report the findings to the Performance Improvement Committee monthly for three months attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members for further recommendations.</p>	

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F 469	Continued From page 18 pest control service representative, revealed the pest control service did monthly on-site visits and could make additional on-site visits when necessary. There had been no notifications from the facility about ineffective fly control or requests for additional service to address the fly problem. An interview with the Administrator, on 08/06/12 at 8:45 AM, revealed she was aware of the fly problem and she had ordered an additional Air Curtain, on 08/03/12, for preventing flies from entering the building, but it would be several days before it would be delivered. There was nothing additional in place to address the fly problem.	F 469			