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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/11/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/09/15 and concluded on 06/11/15 with deficiencies cited at the highest Scope and Severity of a "D".	F 000		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide food which was palatable, attractive and at the proper temperature for one (1) of thirteen (13) sampled residents (Resident #11). Observation revealed two (2) residents' meal trays, which included Resident #11's, were left on the meal tray cart for twenty-two (22) minutes which resulted in the food temperatures not within acceptable limits. The findings include: Review of the facility's policy titled, "Food Service Temperature Control", dated 2009, revealed the tray-line and meal service temperatures for hot food products should be 135 degrees Fahrenheit and cold food should be 41 degrees Fahrenheit or below. Continued review revealed any food	F 364	**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.** JUL 24 2015	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roger W. Perry
TITLE: ADMINISTRATOR
(X6) DATE: 7-23-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	

(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 364	Continued From page 1 which failed to register the correct temperature must be reheated or chilled until acceptable temperatures were reached. Per the Policy, the Nutrition Services Manager or designee was responsible to periodically conduct a temperature audit of foods and beverages for point of service temperatures offered to residents. Further review revealed acceptable temperature standards for point of service, must be maintained as per the state regulations and corrective actions must be taken to maintain food within the proper temperature ranges. Review of Resident #11's medical record revealed the facility admitted the resident on 04/06/15, with the diagnosis which included Diabetes Mellitus, Anemia, Parkinson's and Decline in Functional Status. Review of the Admission Minimum Data Set (MDS) Assessment, dated 04/17/15, and the Significant Change MDS Assessment dated 05/06/15, revealed the facility assessed Resident #11 to have a Brief Interview for Mental Status (BIMS) score which indicated the resident was severely cognitively impaired. However, review of the Social Services re-evaluation of Resident #11 on 06/11/15, revealed the resident had a BIMS score of nine (9) which indicated the resident was moderately cognitively impaired, but interviewable. Observation, on 06/09/15 at 5:30 PM, revealed the dinner meal trays were being delivered to the facility's 100 unit, where Resident #11 resided. Continued observation on 06/09/15 at 5:55 PM, of the dinner meal tray cart, revealed two (2) residents' meal trays remained on the cart and had not been served to the residents, one (1) of which was Resident #11's. Observation at 5:55	F 364	**F 364 (D) 483.35 (d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP** ***Corrective Action for Residents Found to Have Been Affected*** The Dietary Manager immediately served Resident #11 a meal that was within temperature guidelines. A revised distribution system (Exhibit A) is ensuring that Resident #11 is receiving meals that are palatable, attractive and at the proper temperature. Resident #11 has a current BIMS of 9 based on review dated 6-10-2015. ***Identification of Other Residents Having the Potential to be Affected*** On 6-15-2015, a review of the resident meal was completed for the residents that ate in their rooms. The review was conducted by the Dietary Manager, the Director of Nursing, and the Assistant Director of Nursing utilizing an in-room resident list and guidelines (Exhibits B and C). The review demonstrated that residents are receiving meals that are palatable, attractive and at the proper temperature.	

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/11/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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 364	Continued From page 2 PM revealed the two (2) residents' meal trays had been on the meal cart for twenty-two (22) minutes after the meal cart arrived on the unit. Interview, on 06/09/15 at 5:37 PM, with Resident #11 revealed the resident had not been served his/her dinner meal tray when other residents in the room were served theirs. Continued interview revealed Resident #11 was asking where his/her dinner meal tray was. Additional interview, on 06/10/15 at 5:15 PM, with Resident #11 revealed the resident's food was always served last or very late. Per Resident #11, he/she needed assistance with eating his/her meals due to poor vision. Observation and interview, on 06/09/15 at 5:55 PM, revealed the Surveyor asked the Food Service Manager to test Resident #11's dinner meal tray food temperatures. Continued observation and interview revealed the Food Service Manager obtained the food temperatures which were 81.9 degrees Farenheit for the hamburger, 79.2 degrees Farenheit for the potatoes, 71.9 degrees Farenheit for the fruit bowl, 68.4 degrees Farenheit for the tossed salad and 65.5 degrees Farenheit for the thickened tea. Per observation and interview, the food temperatures were not within the proper point of service range and the food did not appear palatable. The Food Service Manager replaced Resident #11's dinner meal tray with a new meal tray immediately. Interview, on 06/10/15 at 6:00 PM, with State Registered Nursing Assistant (SRNA) #2 revealed for residents who required assistance, those residents received their meal trays after the dining room residents were served first. Per	F 364	***Measures or Systemic Changes Made to Avoid Reoccurrence*** A revised in-room meal distribution process was developed and implemented on 6-16-2015. (Exhibit A). A list of residents that prefer to eat in their own rooms will be given to the dietary department from nursing daily (Exhibit C). Residents that are independent or set up assist only with eating that choose to eat in their rooms will be served meal trays first. The residents that require assistance with eating that choose to eat in their rooms will have meal trays plated and served directly from the kitchen. Trays will be requested by nursing staff individually then plated and served directly from the steam table. Staff will then take the tray directly to the resident and assist with feeding meal at the time of tray delivery. Dietary and Nursing staff were in-serviced on the procedure prior to implementation. In-servicing began on 6-16-2015 and was conducted by the Dietary Manager, Staff Development Coordinator and ADON.	

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/11/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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 364	Continued From page 3 interview, there was usually only two (2) SRNA's assigned at meal times to assist residents who ate in their rooms. Interview, on 06/10/15 at 6:10 PM, with SRNA #3 revealed residents who ate in the dining room were served first, then residents eating in their rooms received their trays and were assisted with eating. Per interview, there were five (5) residents on the 100 unit who needed assistance with eating at meal time, one (1) of which was Resident #11. SRNA #3 stated there was usually only two (2) to four (4) SRNA's to assist all the residents on the 100 and 200 units during meal times. In addition, another interview, on 06/11/15 at 9:30 AM, with Resident #11 revealed at breakfast the resident's oatmeal, and biscuit and sausage was always very cold. Per Resident #11, the staff did not offer to warm up his/her foods and did not offer the resident a new meal tray. According to Resident #11, the lunch and dinner meal's foods were a little warmer; however, staff took a long time to serve the residents' meals. Interview, on 06/11/15 at 10:05 AM, with the Dietary Manager revealed tests trays were completed once weekly by the Registered Dietitian (RD) at lunch meal time. Per interview, the residents who needed assistance with their meals, room trays were sent out after the residents who needed assistance in the dining room. The Dietary Manager revealed the hot foods should be 130 degrees Fahrenheit at point of service and cold foods should be 39 degrees Fahrenheit at point of service. According to the Dietary Manager, periodically, she had been told by residents or staff the food was cold and the	F 364	Beginning 6-15-2015, test trays will be checked utilizing a temp log (Exhibit D) by the Dietary Manager or designee, Director of Nursing, ADON, and Registered Dietician (RD) to assure that resident meals are reviewed for palatability, attractiveness and temperature. These checks will alternate residents, locations and times of meals. A minimum of 4 trays per week will be tested. Any issues identified will be corrected immediately. Checks will continue on this schedule for one month minimum then be submitted to the QA Committee for review and recommendations. ***Plans to Monitor Performance for Sustained Solutions*** The Quality Assurance Committee met on 7/8/2015. Meetings were scheduled for 7/17/2015, monthly, and as needed. Audits and reviews will continue to be submitted to the Quality Assurance Committee monthly for review, recommendations and follow-up as needed.	7/9/2015

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/11/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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)	(X6) COMPLETION DATE
F 364	Continued From page 4 food would be reheated or a new meal tray prepared. Further interview revealed the food checked on 06/09/15 at 5:55 PM, was not at the proper temperatures for point of service and there was a potential for bacteria to grow which could cause harm to the resident. Interview, on 06/11/15 at 10:20 AM, with the RD revealed a test tray temperatures were conducted twice a month by the RD. Per interview, the RD alerted dietary staff of any concerns regarding temperatures out of the acceptable range. Continued interview revealed if the food temperatures were out of range at point of service, this could cause a potential for bacteria to grow or allow food borne illness to affect the facility's residents. Per the RD, there was also the potential for the food not to be palatable to the resident if out of the acceptable temperature range. Interview, on 06/11/15 at 11:40 AM, with the Director of Nursing (DON) revealed the facility's usual practice was to split up meal tray service for the residents assisted at meal times, so food temperatures would be within the acceptable range when served. Per interview, if the food was reported as cold, nursing staff should ask the dietary staff to check the food temperature and replace the meal tray with another meal tray. According to the DON, residents' meals should be palatable, and should taste good to the residents with acceptable food temperatures. The DON revealed if food was not served in the acceptable range there could be a potential for bacteria to grow if the meal tray was left sitting too long. Interview, on 06/11/15 at 1:55 PM, with the	F 364		

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/11/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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 364	Continued From page 5 Administrator revealed if food was not hot at the point of service, staff should get another tray from the dietary department for the resident. Per interview, food could become unappealing and affect the resident's appetite if not at the acceptable temperature range, which could cause possible weight loss for the resident.	F 364		

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

PRINTED: 06/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/09/2015

NAME OF PROVIDER OR SUPPLIER: GRAND HAVEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 105 RODGERS PARK, CYNTHIANA, KY 41031

(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 CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1979 Facility Type: SNF/NF Type of Structure: One (1) story, Type V (unprotected) Smoke Compartment: Four (4) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, single station smoke detectors installed in resident rooms 102, 103, 106, 107, 109, 203, 204, 209, and 210. New panel installed 2005. Sprinkler System: Complete sprinkler system (dry). New dry pipe valve installed 11/15/11. Generator: Type 2 generator powered by natural gas A Life Safety Code Survey was initiated and concluded on 06/09/15, for compliance with Title 42, Code of Federal Regulations (CFR), 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela B Sorry Jr

TITLE: Administrator

(X6) DATE: 7-2-15

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.