

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2010
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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064
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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
F 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted on 11/03/10 through 11/05/10 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of "D".</p> <p>F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#5), in the selected sample of 16. Resident #5 had been assessed at risk for aspiration. The resident was served a meal in his/her room and was not supervised by staff while eating. Findings include:</p> <p>A review of the facility's reference guide, "Mosby's Long Term Care Nursing Assistant, 2007 Fifth Edition," revealed older persons were at risk for choking, often related to weakness, dentures that fit poorly, dysphagia and chronic illnesses.</p> <p>A record review revealed Resident #5 was admitted to the facility, on 12/12/08, with diagnoses to include Dysphagia, Hematemesis, Peptic Ulcer, Dementia, Anxiety, Gastroparesis,</p>	F 000	<p>The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein.</p> <p>To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections.</p> <p>The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 11/8/10.</p> <p>F323 Supervision to Prevent Accidents/Hazards</p> <p>1. Resident # 5 has been supervised with all meals by CNA's, licensed staff, and CMA's since 11/5/10 during any oral intake.</p> <p>2. Residents at risk for aspiration have the potential to be affected. Those residents include all residents that are receiving a diet other than indicated appropriate by speech therapy.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 11-30-10

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 CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
(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 323	<p>Continued From page 1</p> <p>Barrett's Esophagus, Anemia and Pneumonia.</p> <p>A review of the annual Minimum Data Set (MDS), dated 02/09/10, revealed the facility identified Resident #5 as moderately cognitively impaired and was totally dependent with eating, related to a tube feeding.</p> <p>A review of the physician's orders, dated 06/23/10, revealed speech therapy was to evaluate and treat Resident #5, related to a diet upgrade requested by the resident's family. A review of the rehabilitation services progress notes, dated 06/30/10 and 07/07/10, revealed the resident had shown signs and symptoms of aspiration, during three of five trials with pureed foods, pudding, and yogurt.</p> <p>A review of a facility form entitled, "Release for Oral Intake" and dated 07/09/10, revealed the resident's Power of Attorney (POA) was informed by the facility of the complications of aspiration, if oral intake of food and liquids was continued; however, the POA decided against the recommendation. The release was signed by the resident's physician, POA, Charge Nurse, and Speech Pathologist. A review of the physician's orders, dated 07/09/10, revealed speech therapy was discontinued and yogurt, ice cream, and milkshakes were added to the resident's diet.</p> <p>A review of the "Plan of Care" for the Certified Nurse Aides, dated November 2010, revealed Resident #5 was described as independent with liquids. The "Plan of Care" did not identify the resident as at risk for aspiration or specify supervision during meals.</p> <p>An observation, on 11/04/10 at 12:00 PM,</p>	F 323	<p>3. Staff were educated by the Director of Nursing to supervise residents that are on aspiration precautions during all po intake. Education was completed for all nursing staff on 11/8/10. Aspiration precautions will be noted on the aide care sheets for the residents that are at risk for aspiration by the Supervisor as orders are taken off. Current nurse aide care sheets were updated. A list of residents with aspiration precautions will be maintained at the nurse's station in the nurse aide 24 hour plan of care book. This will be monitored the first week of the month by the Unit Managers and checked each time orders are received to ensure it was added to the book. The Director of Nursing or designee will observe meals for compliance at least once daily.</p>		

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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F 323	<p>Continued From page 2</p> <p>revealed Resident #5 was taken to his/her room and served lunch. The resident's lunch tray included lemonade, water, tea, milk, yogurt and a milkshake. Certified Nurse Aide (CNA) #1 set up the resident's tray and left the room. The observation revealed Resident #5 was left unsupervised for a thirty minute time period.</p> <p>An interview with CNA #1, on 11/04/10 at 11:15 AM, revealed Resident #5 did not need assistance while eating. She stated Resident #5 ate in his/her room and she was not aware the resident was at risk for aspiration.</p> <p>An interview with the Unit Manager, on 11/05/10 at 10:45 AM, revealed the resident was at risk for aspiration. She stated, "We kept the resident in view during meals, either someone was in the room with the resident or Resident #5 was at the nurse's desk".</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/05/10 at 1:40 PM, revealed the CNAs knew the resident was an aspiration risk. She stated if the resident was in his/her room, staff were supposed to check on the resident at least every five minutes during meals.</p> <p>An interview with CNA #2, on 11/04/10 at 10:35 AM, revealed, "The resident does pretty good while eating". She stated she was not aware the resident was at risk for aspiration.</p> <p>An interview with CNA #3, on 11/04/10 at 11:30 AM, revealed she had been trained six months ago on the resident's hall, but was never told the resident was at risk for aspiration. She revealed the resident did not need assistance during meals and ate most meals in his/her room.</p>	F 323	<p>4. The compliance for this process will be monitored on a daily basis by the Director of nursing or designee and documented on the clinical review documentation from the clinical meetings which are held daily Monday-Friday. Weekend clinical review documentation is reviewed on Monday. The Clinical review documentation will be maintained by the Director of Nursing or designee and reviewed each week and reported in the QA meetings each month. Date of compliance is</p>	11/8/10	

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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F 323	Continued From page 3 An interview with the Director of Nursing (DON), on 11/05/10 at 3:10 PM, revealed the resident was at risk for aspiration, but rarely had meals in his/her room. She revealed frequent checks, at least every fifteen minutes, should be completed for all residents who had meals in their room. The DON expected the CNAs to be made aware of any resident at risk for aspiration during shift report. She stated, "I cannot imagine anyone saying they were not aware of the resident's risk for choking."	F 323			

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 11/04/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robert Briley by Kelly Stone, RN Director of Nursing TITLE
11/23/10 (X6) DATE

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