

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

PRINTED: 09/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2010
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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F 000	INITIAL COMMENTS A standard health survey was conducted on 08/31/10 - 09/03/10 and a Life Safety Code Survey was conducted on 08/31/10. Deficiencies were cited with the highest scope and severity of a "G" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to promote care for three (3) of nineteen (19) sampled residents (#1, 18, 19) in a manner and environment that enhanced each resident's dignity and respect in full recognition of his/her individuality. The facility failed to provide privacy for Resident #1 while in bed. The facility failed to provide dignity bags to cover the catheter bags for Residents #18 and #19. The findings include: Observation of Resident #1 on 08/31/10 at 11:15am revealed that Resident #1 was laid in the bed with the window blinds open. Observation at 3:30pm revealed Resident #1 was back in the room and placed in the bed and the window blinds were left open to the outside, and the door open to the hallway. Observation at	F 241	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Care and Rehabilitation Center does not admit that the deficiencies listed on this form exists, 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.” F 241 1. Residents # 18 and #19 no longer reside at the facility. Resident #1's blinds were closed and on-duty nursing staff was re-educated by DNS on 9/1/10 to provide privacy for Resident #1 and any other resident that may be affected by this practice. 2. Residents residing in the facility had the potential to be affected. 3. Staff will be re-educated by the DNS on or before 09/30/10 on privacy, to include closing window blinds, doors to hallway while providing care and covering catheter bags.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Steve M. Kurling* TITLE: *Administrator* (X6) DATE: *9/27/10*

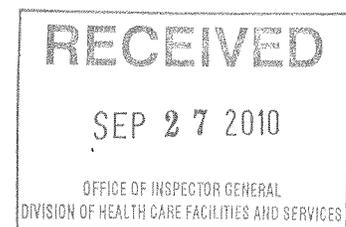
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

SEP 27 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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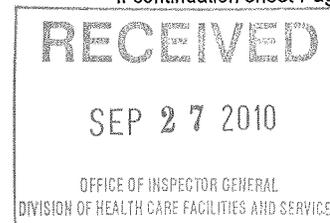
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F 241	<p>Continued From page 1</p> <p>4:31pm revealed the resident laid in bed with bilateral feet up in the the window sill, the window blinds open to the outside, and the door open to the hallway.</p> <p>Observation of Resident #18 on 08/31/10 at 11:33am, and on 09/01/10 at 10:02am revealed a catheter bag with yellow liquid hung on the bedside rail without a dignity bag cover on the catheter bag and viewed from the hallway.</p> <p>Observation of Resident #19 on 08/31/10 at 11:15am and at 11:30am revealed a catheter bag with yellow liquid hung on the bedside rail without a dignity bag cover on the catheter bag and viewed from the hallway</p> <p>Interview on 09/01/10 at 9:30am with Certified Nurse Assistant (CNA) #2 and #3 revealed the window blinds are suppose to be down for privacy when a resident has returned to bed for their rest period. CNA #2 and CNA #3 reported they were unsure who had returned Resident #1 to bed and left the window blind open and the door open to the hallway.</p> <p>Interview on 09/01/10 at 10:00pm with CNA #8 revealed all residents with a catheter bag are to have a blue dignity bag over the catheter bag for dignity and privacy of the catheter. The CNA reported the blue bag is to keep the urine collection bag in for the dignity of the resident. The CNA reported sometimes they have to remind the new CNAs they are to put the blue bags on the urine collection bags, but every resident is suppose to have a blue bag over the urine collection bag.</p> <p>Interview on 09/01/10 at 10:03pm with Licensed</p>	F 241	<p>4. The DNS and/or Unit Manager will conduct rounds three (3) times weekly for one month, weekly for four (4) weeks, then monthly for one (1) month to monitor for closing of doors and windows for privacy along with catheter bags covered.. The DNS will review trends in the Performance Improvement Committee meeting monthly for three (3) months for discussion and review.</p> <p>5. Date of Compliance: October 11, 2010.</p>	



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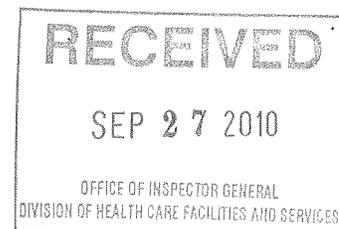
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F 241	Continued From page 2 Practical Nurse (LPN) #2 revealed all residents with a catheter bag are to have a blue dignity bag over the catheter bag for dignity and privacy of the catheter. The LPN reported the blue bag is to keep the urine collection bag in for the dignity of the resident. Interview on 09/01/10 at 10:05pm with CNA #6 revealed all residents with a catheter bag are to have a blue dignity bag over the catheter bag for dignity and privacy of the catheter. The CNA reported the blue bag is to keep the urine collection bag covered for the dignity of the resident.	F 241		
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 and interview it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility failed to keep the resident's dining room furniture clean, wheelchair arm rests were in disrepair, the fish tank was not maintained, and resident equipment was soiled and not maintained. The findings include: Observation on 08/31/10, 09/01/10, and 09/02/10 revealed eight (8) resident wheelchairs had arm rest that were torn, rough and had	F 253	F253 1. The identified dining room chairs were cleaned on 9/6/10 and again on 9/20/10; the fish tank was cleaned and the pump was repaired on 9/16/10; the Sara lift foot rest and wheelchair scale were cleaned on 9/6/10; the identified area in the shower room was cleaned on 9/6/10 and caulking was replaced on 9/23/10; the shower faucet was repaired on 9/16/10; the overbed light cords were replaced on 9/20/10. The preceding was completed by the Maintenance Director. 2. All residents had the potential to be affected. The Maintenance Director and Environmental Service Supervisor completed a facility-wide observation to identify other environmental concerns on 9/03/10. All items identified will be cleaned, repaired or replaced as indicated.	



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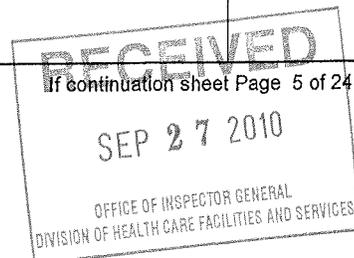
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F 253	<p>Continued From page 3 interior foam exposed.</p> <p>Observation on 08/31/10, 09/01/10, and 09/02/10 revealed the six (6) resident dining room arm chairs were soiled with dried brown, reddish, crusty particles on the frames of the seats and the upholstery was soiled and stained.</p> <p>Observation on 08/31/10, 09/01/10, and on 09/02/10 revealed the fish tank in the living room had green, murky water in the tank. The interior glass of the tank wall had a growth of green and black substance attached. The fish tank water had a foul, stale odor. The fish tank had one of two pumps not functioning.</p> <p>Observation on 09/02/10 at 4:38pm of the wheelchair scales and the SARA lift foot rest revealed brown, gritty loose particles on the base.</p> <p>Observation on 09/02/10 at 4:38pm of the shower chair, tub, and sink revealed caulk was missing and there were loose brown particles around corners and edges of shower room floor. The shower faucet was missing parts.</p> <p>Observation on 09/02/10 at 5:11pm revealed missing light cords for the over the bed lights in Resident Rooms 308 and 310. The residents did not have a method to turn on and off their over the bed lights in their rooms.</p> <p>Interview with the Director of Environmental Services on 09/02/10 at 4:55 pm revealed she is responsible for the cleaning of the facility and all the housekeeping services. She stated she did not have a tracking tool in place to track with a cleaning schedule to maintain the various areas. She reported it is all her staff can do to take care</p>	F 253	<p>3. The Environmental Service Supervisor and the Maintenance Director were educated by the administrator on 9/24/10 regarding how to develop a tracking tool to use to document self-identification needs of the facility for their respective areas of responsibility. The Environmental Service Supervisor will add identified areas to the regular cleaning schedule and will monitor and document cleaning is taking place weekly for three (3) months. Additionally, the Environmental Service Supervisor and Maintenance Director will complete a monthly room audit to self-identify areas of need. The Administrator will monitor and sign off for three (3) months to validate and ensure this process is taking place.</p> <p>4. The monthly audits completed by the Environmental Services Supervisor and Maintenance Director will be brought to the PI Committee for three (3) months for discussion and review.</p> <p>5. Date of Compliance: October 11, 2010.</p>	



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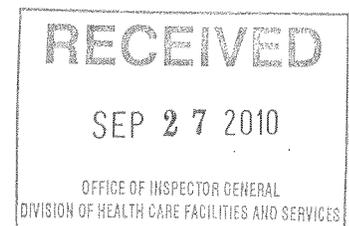
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F 253	<p>Continued From page 4</p> <p>of the resident rooms, and she tries to pick up on all the other areas in the facility. She reported she cleans the areas or items that staff request of her. She reported the staff have never asked her to clean the SARA Lift or the wheelchair scales, so therefore, she doesn't clean any areas not identified.</p> <p>She reported she does the cleaning in the dining room and reported the upholstery in the chairs are stained and dirty. She reported these areas are her responsibility to keep clean and that they are dirty. She reported the fish tank had been maintained with a company several months back, but was currently maintained by the Maintenance department at the facility. She reported she wasn't sure if the murky, greenish, stale, foul smelling fish tank was a infection control concern or not. She reported she is responsible to ensure her staff have completed their task while at work, and could provide no evidence of logs to track and ensure their task were completed. She could not provide any documentation to track cleaning schedules.</p> <p>Interview with the Director of Maintenance on 09/02/10 at 5:15pm revealed he was responsible for the maintenance of the facility. He reported he had just recently come back to work after a leave. He reported he was not aware the resident light cords were missing from resident rooms #308 and #310. He reported he had a work order log, but none of those items were on it. He reported he did not have a tracking tool to check the rooms for areas of need, simply fixes what ever is brought to his attention. He reported he had worked on the fish tank (added water) on 09/01/10 and there was a pump not working on the fish tank. He reported he had no concerns regarding the fish tank with the green, murky,</p>	F 253		



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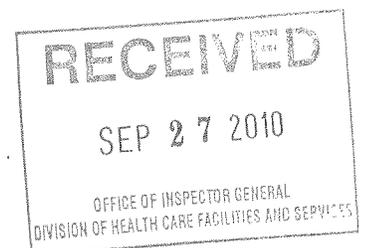
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F 253	Continued From page 5 stale, foul smelling fish tank, and did not see an infection control concern. He reported he was not aware the faucets in the shower room were missing, or for how long, but, it was his responsibility to maintain them. He reported it is his responsibility to maintain the plumbing and the physical environment of the facility. He reported he did not have a tracking tool to assess and complete work, just fixes things as they need to be done.	F 253			
F 279 SS=G	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, record review and interview, the facility failed to review and revise	F 279	F 279 1. Resident # 2 was re-assessed for falls risk and root cause analysis of falls on 9/24/10 by the unit manager. The falls care plan was updated on 9/24/10 by the unit manager to reflect effective interventions. 2. IDT team reviewed on 9/24/10 all residents care plans who are at risk for falls per falls risk assessments to ensure that the care plans reflect effective interventions. 3. Nursing staff will be re-educated by the DNS on or before 09/30/10 regarding falls evaluations including root cause analysis, initiating interventions/assistive devices as needed per root cause analysis, updating care plans to reflect effective interventions per the root cause analysis. The IDT will monitor, in morning stand up, appropriate interventions by reviewing residents with falls to ensure		



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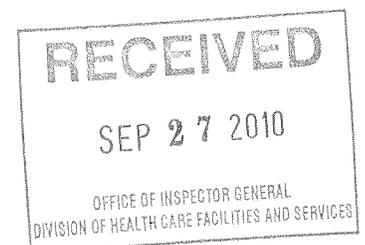
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F 279	<p>Continued From page 6</p> <p>one (1) of nineteen (19) sampled residents, comprehensive plan of care after Resident #2 sustained a fall on 07/01/10. The facility failed to review and revise the residents care plan to ensure the interventions implemented were effective. This failure resulted in Resident #2 having a second fall on 07/04/10 sustaining a laceration to the head, requiring nine (9) sutures and a non-displaced clavicle (collar bone) fracture.</p> <p>The findings include:</p> <p>Record review of the facility's Care Plan Policy dated 01/08 revealed it is the policy of the facility to develop an individualized plan of care for each resident utilizing the information gathered during each assessment.</p> <p>Record review on 09/02/10 of the facility's Accident/Incident Policy dated 01/08 revealed 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 accident and/or falls, and adequately plans care and implements procedures to prevent accidents.</p> <p>Review of Resident #2 's record revealed the facility admitted the resident on 11/06/09 with the diagnoses of chronic airway obstruction (impaired ability to breath), anxiety, malaise (generalized discomfort), fatigue (exhaustion), shortness of breath, subdural hemorrhage (bleeding near the brain), dysarthria (speech disorder), aphasia (language disorder), and failure to thrive.</p> <p>Review of the quarterly Minimum Data Set (MDS) of 05/04/10 revealed the facility assessed the</p>	F 279	<p>appropriate interventions or assistive devices are in place and that the care plan is updated to reflect effective interventions. Prior to the IDT review, the charge nurse will review residents care plans post fall to ensure appropriate interventions or assistive devices are in place and the care plan is updated to reflect effective interventions.</p> <p>4. DNS and/or Unit Manager will review five (5) resident care plans weekly for four (4) weeks, then monthly for two (2) months to ensure current interventions and assistive devices are in place and care plans are updated to reflect current needs. The DNS will report trends in the Performance Improvement Committee meeting monthly for three (3) months for discussion and review.</p> <p>5. Date of Compliance: October 11, 2010.</p>	



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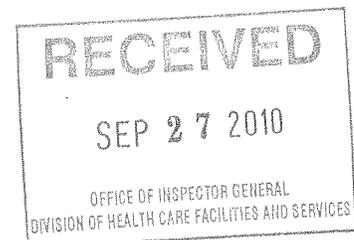
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F 279	<p>Continued From page 7</p> <p>Resident as having no cognitive impairment and was able to be understood and did understand. Review of the falls risk care plan dated 05/11/10 revealed the resident had an unsteady gait, weakness and a history of two (2) previous falls.</p> <p>The care plan dated 11/18/09, detailed the follow interventions: 1) Encourage Resident to rest when necessary. 2) Standby assist with walker for ambulation, 3) Monitor and document for changes in behavior, such as increased agitation, decline in mental status, etc. 4) Keep call bell within reach of resident. 5) Provide Resident with clean glasses daily. 6) Complete fall assessment per protocol. 7) Explain care/activities prior to initiating. 8) Provide well lit, clutter free environment. 9) Keep frequently used objects within reach. 10) Stargazer. 11) Prefers to use left half side rail as an enabler. Review of the care plan interventions review date was on 02/11/10 and on 05/06/10 and no additional interventions were added or deleted.</p> <p>The resident's care plan dated 11/18/09, and reviewed on 02/11/10 and 05/06/10 did have the resident care planned as a fall risk related to a history of two (2) falls with injury while in the hospital. Factors to the resident's fall included the use of trazodone, weakness, and an unsteady gait. Educate the resident and the continuation of therapy for strengthening were the only interventions added to the care plan on 07/01/10 by the floor nurse.</p> <p>Record review of the nurses note dated 07/01/10 revealed the Resident was educated by RN #3 on purse lip breathing techniques and to receive assistance with transfers. The nurses notes on 07/01/10 at 2:30pm when the nurse was called to</p>	F 279		



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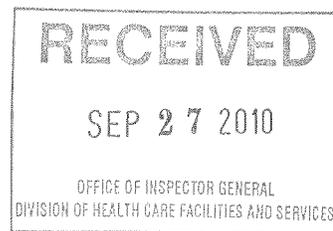
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F 279	<p>Continued From page 8</p> <p>the sunroom with the resident in the floor documented the Resident had generalized weakness and increased fatigue with activities.</p> <p>Resident #2 had a second fall, which occurred on 07/04/10 in his/her room. The facility transferred the resident to the emergency room for treatment on 07/04/10 for a laceration to head, which required nine (9) sutures and pain to the right shoulder. The resident sustained a non-displaced fractured clavicle (collar bone).</p> <p>The nurses notes dated 07/04/10, after resident returned from the Emergency Department, revealed the clip alarm was now on the resident. The care plan was updated but had no date identified for Resident #2's use of a clip alarm while in bed related to an unsteady gait and assistance is needed with ambulation. The clip alarm use was first documented in the nurses notes on 07/04/10 after the resident returned from the emergency room visit.</p> <p>The care plan dated 07/12/10 for Resident #2 revealed the clip alarm and assistance with ambulation were discontinued on 07/12/10 and revised on 07/12/10 to use a pressure alarm to the bed and wheelchair related to decreased safety awareness.</p> <p>Interview with the Certified Nurse Assistant #7 on 09/02/10 at 6:32pm revealed she/he as a caregiver did not receive any new or additional updates regarding Resident #2's fall or any additional intervention to meet his care needs.</p> <p>Interview with the Registered Nurse (RN) #3 on 09/02/10 at 5:30pm revealed he/she educated and reminded the resident to use their call light</p>	F 279		



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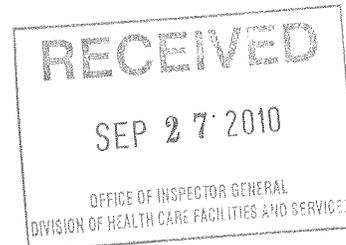
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2010
NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065	
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F 279	Continued From page 9 and to ask for help after his/her fall on 07/01/10 (first fall). The RN reported he/she had documented everything in the nurses notes. The RN reported the Resident had been spending time in the sunroom. Interview with the Director of Nursing on 09/02/10 at 7:10pm revealed that Resident #2's fall that occurred on 07/01/10 was not reviewed by the Interdisciplinary Team (IDT) until the following Tuesday, 07/06/10, due to the weekend and the 07/04/10 holiday. She did reveal the fall on 07/04/10 potentially could have been prevented if the IDT team had met and reviewed the care plan and interventions that were in place at the time the fall occurred on 07/01/10 and identified the root causes of that fall. Then additional interventions such as alarms for the bed and wheelchair could have been put into use prior to the second fall on 07/04/10. Record review of the physician orders and progress notes dated 07/09/10 revealed the Resident had a fall over the weekend resulting in a non-displaced right clavicle (collar bone) fracture (broken bone) and a small subdural (blood clot near the brain) hematoma. The physician documented a decline in the residents condition and documented the family requested comfort measures.	F 279		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		



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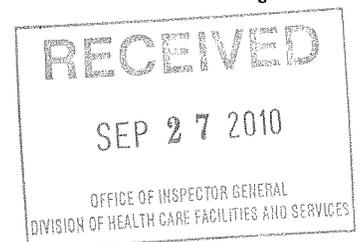
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F 323	Continued From page 10 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one (1) resident of the nineteen (19) sampled residents, Resident #2, remained free of accidents. Resident #2 had a fall on 07/01/10 and then sustained a second fall that resulted in a clavicle (collar bone) fracture on 07/04/10. The findings included: Record review of the facility's Accident/Incident Policy dated 01/08 revealed 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 accident and/or falls, and adequately plans care and implements procedures to prevent accidents. Review of Resident #2 's record revealed the facility admitted the resident on 11/06/09 with the diagnoses of chronic airway obstruction (impaired ability to breath), anxiety, malaise (generalized discomfort), fatigue (exhaustion), shortness of breath, subdural hemorrhage (bleeding near the brain), dysarthria (speech disorder), aphasia (language disorder), and failure to thrive. Review of the quarterly Minimum Data Set (MDS) of 05/04/10 revealed the facility assessed the	F 323	F 323 1. Resident # 2 was re-assessed for falls risk and root cause analysis of falls on 9/22/10. The falls care plan was updated on 9/22/10 by the Unit Manager to reflect effective interventions. 2. Residents who are at risk for falls per the falls risk assessments were re-evaluated by the IDT team on 9/24/10 to ensure effective interventions are in place to prevent falls. Updates were made to care plans as needed by the IDT. 3. Nursing staff will be re-educated by the DNS on or before 09/30/10 regarding falls evaluations including root cause analysis, initiating interventions/assistive devices as needed per root cause analysis, updating care plans to reflect effective interventions per the root cause analysis. This process will be completed upon admission, quarterly, post fall, and with changes in health status and as needed per IDT. The IDT will monitor in the clinical stand up meeting by reviewing residents with falls to ensure that the root cause analysis has been completed and interventions/assistive devices per root cause analysis are updated on the care plans to reflect effective interventions. Prior to the IDT review, the charge nurse will review residents with falls to ensure	



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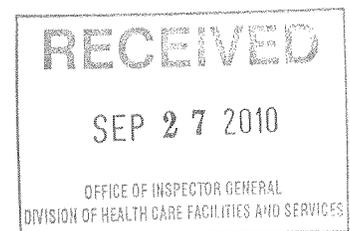
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F 323	<p>Continued From page 11</p> <p>Resident as having no cognitive impairment and was able to be understood and did understand. Review of the falls risk care plan dated 05/11/10 revealed the resident had an unsteady gait, weakness and a history of two (2) previous falls.</p> <p>The care plan dated 11/18/09, detailed the follow interventions: 1) Encourage Resident to rest when necessary. 2) Standby assist with walker for ambulation, 3) Monitor and document for changes in behavior, such as increased agitation, decline in mental status, etc. 4) Keep call bell within reach of resident. 5) Provide Resident with clean glasses daily. 6) Complete fall assessment per protocol. 7) Explain care/activities prior to initiating. 8) Provide well lit, clutter free environment. 9) Keep frequently used objects within reach. 10) Stargazer. 11) Prefers to use left half side rail as an enabler. Review of the care plan interventions review date was on 02/11/10 and on 05/06/10 and no additional interventions were added or deleted.</p> <p>The resident's care plan dated 11/18/09, and reviewed on 02/11/10 and 05/06/10 did have the resident care planned as a fall risk related to a history of two (2) falls with injury while in the hospital. Factors to the resident's fall included the use of trazodone, weakness, and an unsteady gait. Educate the resident and the continuation of therapy for strengthening were the only interventions added to the care plan on 07/01/10 by the floor nurse.</p> <p>Record review of the nurses note dated 07/01/10 revealed the Resident was educated by RN #3 on purse lip breathing techniques and to receive assistance with transfers. The nurses notes on 07/01/10 at 2:30pm when the nurse was called to</p>	F 323	<p>that the root cause analysis has been completed and interventions/assistive devises per root cause analysis are updated on the care plans to reflect effective interventions.</p> <p>4. DNS and/or Unit Manager will review five (5) resident care plans weekly for three (3) months to ensure effective interventions are in place and care plans are updated. The DNS will report trends in the Performance Improvement Committee meeting monthly for three (3) months for discussion and review of any trends.</p> <p>5. Date of Compliance: October 11, 2010.</p>	



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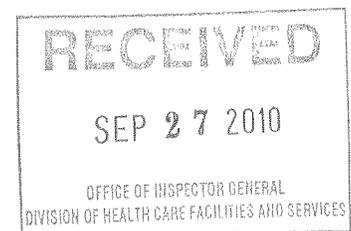
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F 323	<p>Continued From page 12</p> <p>the sunroom with the resident in the floor documented the Resident had generalized weakness and increased fatigue with activities.</p> <p>Resident #2 had a second fall, which occurred on 07/04/10 in his/her room. The facility transferred the resident to the emergency room for treatment on 07/04/10 for a laceration to head, which required nine (9) sutures and pain to the right shoulder. The resident sustained a non-displaced fractured clavicle (collar bone).</p> <p>The nurses notes dated 07/04/10, after resident returned from the Emergency Department, revealed the clip alarm was now on the resident. The care plan was updated but had no date identified for Resident #2's use of a clip alarm while in bed related to an unsteady gait and assistance is needed with ambulation. The clip alarm use was first documented in the nurses notes on 07/04/10 after the resident returned from the emergency room visit.</p> <p>The care plan dated 07/12/10 for Resident #2 revealed the clip alarm and assistance with ambulation was discontinued on 07/12/10 and revised on 07/12/10 to use a pressure alarm to the bed and wheelchair related to decreased safety awareness.</p> <p>Interview with the Certified Nurse Assistant #7 on 09/02/10 at 6:32pm revealed she/he as a caregiver did not receive any new or additional updates regarding Resident #2's fall or any additional intervention to meet his care needs.</p> <p>Interview with the Registered Nurse (RN) #3 on 09/02/10 at 5:30pm revealed he/she educated and reminded the resident to use their call light</p>	F 323		



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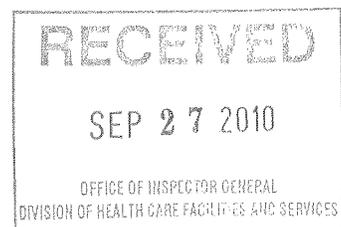
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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371			



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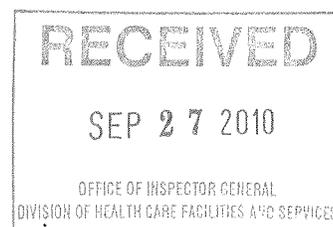
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F 371	<p>Continued From page 14</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Staff failed to follow proper handwashing protocol, flour was let open in the dry storage area, plates, utensils, and slicer were found soiled, and cleaning solution used to disinfect kitchen surfaces was not in the proper chemical sanitation range.</p> <p>The findings include:</p> <p>Review of facility policies updated 07/08 revealed the center policy stated that all foods are prepared in accordance with the USDA Food code. In addition, the Nutritional Service Director (NDS) ensures that all staff practice proper hand washing technique and is responsible for food preparation procedures.</p> <p>Observation during the initial tour of the kitchen on 08/31/10 at 08:30am revealed one cook wore no hair covering. The slicer had brown crusted particles on the bottom back side of the blade. Observation of dishes and utensils ready to use included one saucer with dried food like particles. A spatula ready to use was chipped and cracked. The utensil drawer contained food-like particles.</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> 1. The identified cook was counseled on 8/31/10 regarding the wearing of hairnets; the slicer blade was immediately sanitized; the identified saucer was placed back to be re-washed; the spatula was thrown away; the utensil drawer was cleaned immediately; the identified tongs were cleaned immediately; the bag of flour was re-closed when identified; the cleaning solution was changed per schedule and tested appropriately. 2. All residents had the potential to be affected. A dietary sanitation audit was completed by the Dietary Manager on 9/23/10. No areas of concern were identified. 3. The Dietary Manager will re-educate the dietary staff on or before 9/28/10 regarding hairnet requirement, proper cleaning of equipment, re-washing plates and/or utensils if dirty after washing, taking worn cooking equipment out of circulation when not in good repair, proper storage of dry goods after use, proper way to go between clean and dirty 	



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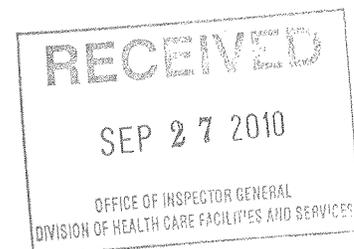
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F 371	<p>Continued From page 15</p> <p>The tongs ready for use had dried food like particles inside the handle. In the dry storage area, a bag of flour was open to air.</p> <p>Observation on 09/01/10 at 11:05 during tray line revealed Cook #2 was working on the steam table. Cook #2 retrieved a spoon from the rinse sink, handed it to another employee to wash in the dishwasher, then returned to the steam table without washing her hands.</p> <p>Interview with Cook #2 on 09/01/10 at 11:15am revealed she retrieved the spoon from the rinse sink. When ask if those dishes were clean, she stated no because they had to be run through the dishwasher for final heat sanitizing. She stated she should have washed her hands after retrieving something from the dirty sink area.</p> <p>Continued observation of the tray line on 09/01/10 during lunch service revealed Cook #2 ran out of plates. Cook #2 removed six plates during tray line due to soilage. Cook #2 ask the Dietary Manager to wash a plate to serve the last tray. The Dietary Manager ran the plate through the dishwasher, removed it from the dishwasher and handed it to the cook who then served mashed potatoes. The plated was observed with multiple water droplets. When asked if it was acceptable to serve food on wet dishes, the Dietary Manager said no it should not have been used to serve food until dry.</p> <p>Observation during the sanitation tour on 09/01/10 at 10:45am revealed the chemical cleaning solution used to disinfect surfaces was strip tested at 150 parts per million (ppm) rather than between 200 - 400ppms..</p>	F 371	<p>areas, proper procedure for immediate use of items having water droplets on them and following facility procedures related to the sanitizing solution. The AM cooks will check daily the meat slicer daily for cleanliness. The AM and PM cooks will check daily the dry food store room to ensure no items are open, as well as checking the sanitizing solution and recording solution strength on Sanitizer log.</p> <p>4. The Dietary Manager will include all identified concerns and include them in her daily M-F sanitation walk-through to ensure compliance for three (3) months. The RD will also include these areas in her monthly sanitation audit for three (3) months. The Dietary Manager will bring weekly sanitation audits and monthly RD sanitation audit to PI Committee for three (3) months for discussion and review.</p> <p>5. Date of Compliance: October 11, 2010.</p>	



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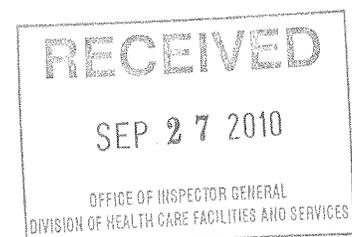
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F 371	<p>Continued From page 16</p> <p>An interview with the Dietary Manager on 09/01/10 at 10:45am revealed that the cleaning solution should be at least 200 part per million. She stated that the solution had been there since breakfast and the staff was getting ready to change the solution. She stated the normal routine is to change the solution before every meal, and test the solution to ensure it is within range for proper disinfection.</p> <p>Interview with Cook #1 on 09/02/10 at 4:00pm revealed he did not wear a hair covering on 08/31/10 at 8:30am. He stated he could not find a hair net when he had come in that morning. He agreed it was not acceptable to be in the kitchen without a hair net because hair could get in the food that is served to the residents.</p> <p>An interview with the Dietary Manager on 09/02/10 at 3:15pm revealed she is responsible for monitoring of the staff to ensure they are following policies and procedures of the facility. She acknowledged that Cook #2 was not wearing a hair net on 08/31/10 and she told him to put one on after we arrived. The Dietary Manager stated she educated her staff on wearing hair nets, going from dirty to clean, proper hand hygiene, and proper chemical disinfection. The Dietary Manager stated she is capable of removing the slicer blade for cleaning and that staff are trained on cleaning the slicer, but she prefers them not to do it to avoid possible injury from the sharp blade. She stated maintenance is contacted to remove the blade for cleaning as needed. The Dietary Manager further stated the brown crusted particles on the back of the blade wasn't food, but rather something that had blown in from the back</p>	F 371		



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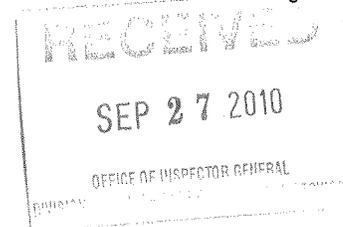
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F 371	Continued From page 17 door, as the slicer sits on the bottom shelf near the back door. An interview with the Registered Dietician (RD) on 09/01/10 at 2:30pm revealed she does sanitation audits on a monthly schedule. A review of the June 10, 2010 audit revealed she had noted concerns with dirty dishes, wet dishes, and general sanitation issues. She agreed the score of 49% was not acceptable and that they try for 80% compliance. She stated she communicated concerns with the Dietary Manager via phone calls and a binder that is kept in the Dietary Managers office.	F 371		
F 441 SS=E	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	F 441	F 441 1. Residents #1 and #7 were assessed for sign and symptoms of infection on 9/04/10 by the unit manager. None were found with S/S infection. Resident # 3 and #9 no longer reside in the center. 2. All residents in the facility had the potential to be affected. 3. Nursing staff will be re-educated by the DNS on or before 10/8/10 on infection control policies and procedures including: Universal precautions and standard infection control practices during wound care, skin assessments, G-tube care, and peri-care, including return demonstrations.	



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F 441	<p>Continued From page 18</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 by: Based on observation, interview and record review it was determined that the facility failed to maintain an infection control program to provide a safe and sanitary environment in the prevention and the development of the spread of infection for four (4) of nineteen (19) sampled residents (#1, #3, #7, #9). Staff failed to maintain standard infection control practices during a wound care dressing change for Resident #3, skin assessment for Resident #7, peri-care for Resident #1 and wound care for Resident #9.</p> <p>The findings include:</p> <p>Observation on 09/02/10 at 7:30am of Resident #3's wound care dressing change revealed Licensed Practical Nurse (LPN) #1 cross contaminated items when changing the dressing to the coccyx and foot. LPN #1 began to change the dressing to the coccyx and placed the clean scissors on Resident #3's bed for use. LPN #1 then picked up the contaminated scissors from</p>	F 441	<p>4. DNS and /or unit manager will monitor infection control practices to ensure compliance by observation of resident care weekly four (4) weeks, then monthly for two months. The DNS and/or unit manager will review trends in the Performance Improvement Committee meeting monthly for three (3) months for discussion and review.</p> <p>5. Date of Compliance: October 11, 2010.</p>



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2010	
NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065		
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F 441	<p>Continued From page 19</p> <p>the residents bed and cut the clean dressing with the contaminated scissors. When LPN #1 began to clean the wound to Resident #3's foot, LPN #1 cleaned the scissors, cut a little piece off of the dressing, then placed scissors on Resident #3's bed. LPN #1 then picked up the scissors to cut a little more from off the dressing with the contaminated scissors.</p> <p>Interview on 09/02/10 at 10:55am with LPN#1 revealed the bed is considered a dirty environment. LPN #1 further stated she was aware she placed clean guaze and scissors on the bed, and even though she cleaned the scissors, laying the scissors on the bed contaminated them. LPN #1 further stated that without keeping everything clean she could have infected the wound bed and caused more damage.</p> <p>Observation on 09/01/10 at 2:50pm of LPN #1 revealed that while doing a skin assessment on Resident #7, LPN #1 placed gloves on her hands, checked Resident's #7 face, neck, back and buttocks, then with the same gloves on, detached the tube feeding from the main line, and placed it on top of the pole by the machine. LPN #1 then finished the skin assessment with the same gloves on, picked up the tube feeding line again, then placed it back on to Resident #7.</p> <p>Interview on 09/01/10 at 2:50pm with LPN #1 revealed she should have changed her gloves before touching Resident #7's tubing. She stated gloves are changed to decrease infection.</p> <p>Interview on 09/02/10 at 5:42pm with the Unit Manager revealed that the nurses on the unit are in-serviced on g-tube care and peri-care. The Unit</p>	F 441		

