

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

PRINTED: 01/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2012
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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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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F 000	INITIAL COMMENTS	F 000	Completion Date: December 28, 2012	
F 151 SS=B	<p>AMENDED SOD 01/17/13</p> <p>A standard survey was initiated on 11/18/12 and concluded on 11/20/12 and a Life Safety Code survey was conducted on 11/20/12 with deficiencies cited at the highest scope and severity of a "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>This was a Nursing Home Initiative survey with entrance on Sunday 11/18/12 at 8:45 AM.</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy, it was determined the facility failed to ensure two (2) of nineteen (19) sampled residents and one (1) unsampled resident, Residents #3, #11 and Unsampled Resident A were allowed to exercise their right to vote.</p> <p>The findings include: Record review of the Kentucky Resident Bill of Rights provided by the facility as their policy on Resident Rights revealed each resident was</p>	F 151	<p>F151</p> <p>1. For residents #3 and #11 the Social Service Director apologized for not assuring that they were able to exercise their right to vote in the Presidential Election. Both resident #3 and #11 were added to the Residents Who Want to Vote roster on 12/10/2012 to ensure that they will have the opportunity to vote in the next election.</p> <p>2. On 12/21/2012 the Social Service Director and Social Service Assistant ask the residents of the facility if they had wanted to vote in the past Presidential Election, and if they gotten to exercise their right to vote? Two (2) other residents stated they would have liked to vote in the Presidential Election. Those two (2) residents were added to the Residents Who Wanted to Vote roster on 12/21/2012 to ensure</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X. Elvira

TITLE
X Administrator

(X6) DATE
X 12/26/12

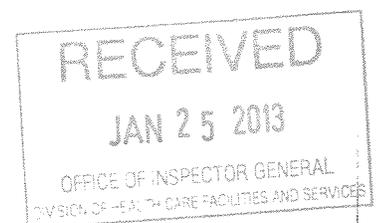
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

JAN 25 2013

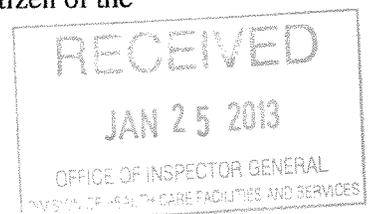
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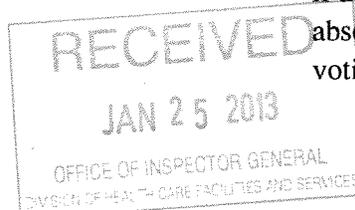
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F 151	Continued From page 1 encouraged to exercise their rights as a citizen. Interview, on 11/18/12 at 1:15 PM, during the Quality of Life Group Interview with Resident #11 and Resident A revealed they had signed a form indicating they wanted to vote in the Presidential election November 2012; however, they were not taken to the polls on election day or given an absentee ballot to complete. Interview, on 11/18/12 at 3:15 PM, with Resident #3, the President of the Resident Council, revealed the resident did not vote in the Presidential election November 2012, although he/she signed a request to vote. The Resident did not receive an absentee ballot, nor go to the polling site to vote. The Resident stated no one followed up with him/her to ensure he/she voted and he/she stated he/she was upset he/she did not get to vote. Interview, on 11/18/12 at 3:35 PM, with Social Services revealed Residents #3, #11 and A did fill out the forms needed to be able to vote in the 2012 Presidential election. Social Services did take other residents to the polls on Election Day. She did not check with all residents who had indicated they wanted to vote to ensure those residents had transportation to the polls and were allowed to exercise their right to vote.	F 151	that they will have the opportunity to vote in the next election. 3. On 12/7/2012 the Social Service Director and Administrator reviewed and updated the policy and procedure for resident voting. Starting 12/10/2012 at admission all residents are ask if they would like to exercise their right to vote by either absentee ballot or voting at a designated voting station. Any resident that has indicated that they would like to vote will be added to an ongoing roster of "Residents who want to vote". The Admissions Coordinator and the Admissions Assistant were in-serviced on 12-10-2012 by the Administrator on the importance of asking every new admission if they wanted to exercise their right to vote while a resident in the facility. The Admissions Coordinator and Admissions Assistant were instructed by the Administrator on 12/10/2012 to	
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		



provide new admissions voting information to the Social Service Department by means of the Facility Directory Information form that is signed upon admission. On 12/21/2012 the Admission Coordinator was inserviced by the Administrator that resident who are admitted a month prior to an election will be told the facility will assist them to their designated voting poll if they so wish to vote. This information will be given to the Social Service Department via the Facility Directory Information form. The Social Service Director and Social Service Assistant were inserviced by the Administrator on 12-10-2012 regarding the right to exercise his/her rights as a resident of the facility and as a citizen of the



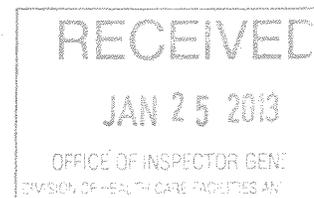
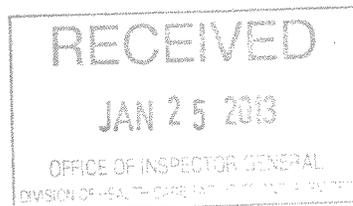
United States to vote. The Social Service Director and Assistant were also inserviced on 12/10/2012 by the administrator that when they receive a Facility Directory Information form from the Admissions department they are to add the resident to the "Residents who want to vote" roster. The Social Service Director and Social Service Assistant were instructed by the administrator on 12-21-2012 to ask all current resident in the facility if they would like to exercise their right to vote in the next election, and to add those residents to the Residents Who Want to Vote roster. (Only residents who have been adjudicated in the court of law are not allowed to vote.) The Social Service Department will utilize the Residents Who Want to Vote roster during election time to ensure residents who want to vote either request an absentee ballot or are given the opportunity to attend the voting polls. On 12/21/2012 the Social Service Director and Social Service Assistant were instructed that with each comprehensive assessment they are to ask the resident if they want to exercise their right to vote in an election. They are also to ask if the resident if they would like to vote by absentee ballot or go to their voting station. Three months



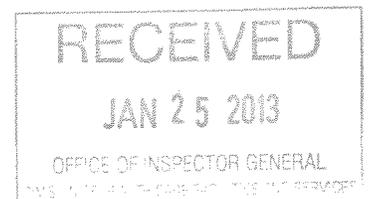
prior to an election the Social Service Director and Social Service Assistant will review the Residents Who Want to Vote roster and once again ask all facility residents if they want to exercise their right to vote in the upcoming election. This will be to ensure residents are able to exercise their right to vote. On 12/10/2012 the Administrative Assistant was inserviced by the Administrator that when there is an election the Residents Who Want to Vote roster will be given to the him/her who will check off the absentee ballots as they arrive in the mail, and then check them off again as they are mailed back out of the facility. Three (3) days prior to the election the Administrative Assistant will give the Social Service Director the Residents Who Want to Vote roster to ensure any resident that wanted to vote, but did not complete a absentee ballot will be taken to the voting polls.

4. In order to ensure that residents who want to vote are asked, and then are able to exercise their right monthly the Social Service department will review all Facility Directory Information forms to ensure they have captured the new admission that want to vote. Also monthly with the MDS schedule of assessments the social service department will ask residents with comprehensive

assessments if they want to exercise their right to vote. If the resident indicated they would like to vote in the next election they will be placed on the Residents Who Want to Vote roster. Then when there is an election for the residents to exercise their right to vote, each resident that is on the Residents Who Want to Vote roster will be asked if they would like an absentee ballot or go to their designated voting station. The resident's choice will be noted on the roster. The roster will be referenced to, to ensure the residents get to request an absentee ballot, and that it gets mailed out or that they are taken to their designated voting station. When there is an election a copy of the completed roster will be given to the Administrative Assistant who will check off the absentee ballots as they arrive in the mail and check them off again as they are mailed back out of the facility. Any resident that is found to not receive a requested absentee ballot the administrative assistant will notify the Social Service Director. Any absentee ballot that is not mailed back out the administrative assistant will notify the Social Service Director so that he/she can make arrangements to for the resident(s) to go to their designated voting station. Monthly the Social Service Director will submit the



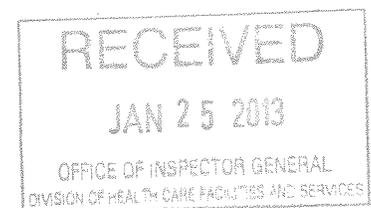
Residents Who Want to Vote roster to the Quality Assurance (QA) Committee. The QA committee will utilize the routine QA information supplied by the Admissions Department and the MDS department to ensure that new admissions and resident with comprehensive assessments were asked, and noted on the Residents Who Want to Vote roster. At anytime the QA committee find that residents from admissions or comprehensive assessments do not appear on the Residents Who Want to Vote roster as either they want to exercise their right to vote or not the QA committee will ask for an explicit written explanation from the Social Service Department as to why the Residents Who Want to Vote roster is incorrect. At that time the Social Service Department will have to start supplying the Administrator with the Residents Who Want to Vote roster on the second and fourth Tuesday of every month. The Administrator will utilize information from the Admissions Department and MDS department to ensure new admissions and residents with comprehensive assessments have been properly added to the roster. Monthly the Administrator will supply an audit of his/her findings to the QA committee.



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F 250	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically-related social services for four (4) of nineteen (19) sampled residents and one unsampled resident (Residents #1, #7, #8 and #11). The facility failed to assess and care plan concerns for Resident #1. The facility failed to address isolation for Residents #7 and #8. The facility failed to assess and care plan Resident #11 for depression.</p> <p>The findings include:</p> <p>Social Services policies were requested, in writing and verbally, and the facility did not provide these policies.</p> <p>Review of the facility policy for Methicillin Resistant Staphylococcus Aureus (MRSA), undated, revealed movement/transfer of the resident with MRSA would be for essential purposes only and residents would dine in their room.</p> <p>1. Observation of Resident #7, on 11/18/12 at 11:00 AM, revealed signage on the room door frame stating Contact Precautions.</p> <p>Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Osteomyelitis with MRSA in the surgical Wound on the Foot secondary to Gangrene. The facility completed an admission Minimum Data Set (MDS) assessment on</p>	F 250	<p>Completion Date: December 28, 2012</p> <p>F 250</p> <p>1. For resident #1 her/his care plan was reviewed and updated by the Social Service Director on 11/21/2012 to reflect her communication issues. On 11/21/2012 Resident #1 was evaluated and began Speech Therapy related to her communication issues. Resident #7s care plan was reviewed and updated by the Social Service Director on 11/21/2012 related to her psychosocial needs while in isolation. Resident #8s care plan was reviewed and updated by the Social Service Director on 11/21/2012 related to her psychosocial needs while in isolation. Resident #11s care plans was reviewed and updated by the Social Service Director on 11/21/2012 related to her depression and the possible side</p>



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F 250	<p>Continued From page 3</p> <p>10/31/12 which revealed the resident was cognitively intact and required extensive assistance with care needs. Resident #7 was noted to have feelings of being down or depressed more than half of the time as a resident.</p> <p>Review of the care plan for Resident #7, revealed no evidence of documentation to address the resident's isolation precautions secondary to MRSA.</p> <p>Interview with the Social Services Director, on 11/20/12 at 10:55 AM, revealed she did not know Resident #7 was in isolation so a care plan was not developed to address the isolation the resident required related to the infection with MRSA. She stated she was responsible for having a good picture of the resident and providing a care plan reflecting the resident's needs.</p> <p>2. Observation of Resident #8, on 11/18/12 at 11:00 AM, revealed signage on the room door frame which indicated Contact Precautions.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with a diagnosis of Clostridium Difficile Colitis. The facility placed the resident in isolation precautions related to the diagnosis. There was no evidence that the resident's isolation was addressed by social services.</p> <p>Interview with the Social Services Director, on 11/20/12 at 10:55 AM, revealed she was not aware Resident #8 was in isolation. She stated she should have written a care plan to address</p>	F 250	<p>effects related to the use of antidepressants. On 12/13/2012 Parkview Psychiatric Services reviewed Resident #11s antidepressant use</p> <p>2. By utilizing the most recent MDS assessment on 11-21-2012 the Social Service Director with the help of the MDS Coordinator identified those residents who had communication issues, who were in isolation, had a diagnoses of depression and who were on an antidepressant. Each of those residents was reviewed for appropriate care plans related to their identified medically related social service needs. Residents that were found to have inappropriate care plans or no care plan addressing the indentified issue was corrected by the Social Service Director on 11/21/2012. By 12/05/2012 Speech Therapy had screened other residents that were identified as having communication issues. By 12/18/2012 the Social Service Director, Unit A</p>		

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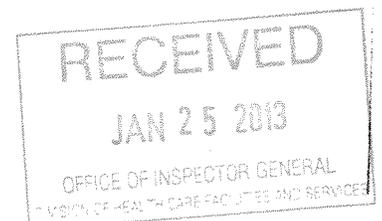
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F 250	<p>Continued From page 4 the resident's isolation and concerns which could result from the isolation.</p> <p>Interview with the Administrator, on 11/20/12 at 3:50 PM, revealed the care plans should have reflected the residents' isolation.</p> <p>3. Review of the medical record for Resident #11 revealed the facility admitted the resident on 11/07/07 with Diagnoses including Hydrocephalus, Diabetes Mellitus Type 2, Convulsions, Depression, Malignant Neoplasm of the brain, Cerebral Meningitis, and a Ventral Shunt. Review of the medications for Resident #11 revealed the resident was taking an antidepressant prescribed since 05/12/10.</p> <p>Review of the Annual Minimum Data Set Assessment (MDS), dated 04/12/12, revealed the facility assessed Resident #11 at cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The facility assessed the resident's mood with a total score of 2 with indications for feeling depressed, down, and hopeless 2 to 6 days during the Assessment reference date. Review of the Care Assessment Area (CAA), revealed the facility indicated the resident triggered for mood state and psychotropic drug use but did not indicate if a care plan was developed.</p> <p>Review of the care plan for Resident #11 revealed the facility did not develop a care plan to monitor for depression or side effects of the antidepressant.</p>	F 250	<p>Coordinator and the Unit B Coordinator will review each residents that is prescribed antidepressants for the appropriateness of the medication and the need for a Gradual Dose Reduction (GDR) if appropriate. Those residents identified as needing a GDR related to their antidepressant will have Parkview contacted on their behalf. With the GDR recommendation from Parkview and the Social Service Director, Unit A Coordinator or Unit B Coordinator the residents primary care physician will be notified.</p> <p>3. The Social Service Director was inserviced on 11/20/2012 by the administrator on the importance of being aware of what is occurring with the residents in the facility. It is the responsibility of the Social Service Director to be aware of</p>		

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F 250	Continued From page 5 Interview with MDS Coordinator #1, on 11/20/12 at 9:20 AM, revealed the Social Worker was responsible for developing care plans for residents on psychotropic medications, related to cognition, mood and behavior. Interview with Social Services, on 11/20/12 at 11:00 AM, revealed she did not believe she was responsible for medically related social services. She went on to say the nurses responsible for the MDS assessments were doing all of the care plans but recently the facility had made a change and she was responsible for care plans for mood and behavior. She acknowledged Resident #11 should have had a care plan for depression with the annual assessment on 04/12/12 as the resident was on an antidepressant and triggered for mood state on the CAA. She stated she was responsible for knowing what the MDS indicated for mood and behavior for Resident #11. Interview with the the Administrator, on 11/20/12 at 3:30 PM, revealed the facility had identified problems with updating and developing care plans and were working on changing the policy on who was responsible for care plans. She stated the MDS nurses were doing most of the care plans but the care plans were not getting revised and updated. 4. Record review of Resident #1 revealed the facility admitted the resident on 01/26/12 with diagnoses of Diabetes Mellitus 2, Dysphagia (difficulty swallowing), Renal (Kidney) Failure, Cerebral Vascular Accident, Hypertension, Depression, Psychosis, Anxiety, Gastro Tube Placement, Multiple Contracures.	F 250	what residents are in isolation and what their psychosocial needs are related to being in isolation. The Social Service Director was also inserviced on 11/20/2012 by the Administrator regarding the need to develop care plans for issues identified in a Care Assessment Area (CAA) such as a resident's mood state and the use of psychotropic and antidepressant medications. The Social Service Director was also inserviced by the administrator on 11/20/2012 the importance of looking at each resident as an individual, and to include other disciplines opinions/input into the care needs of the residents. Such the case with resident #1 the Social Service Director was encouraged to find ways to promote the highest practicable physical, mental, and psychosocial well-being for that resident and each resident in the facility. On 12-3-2012 a social service policy was created and implemented. The policy covered the necessity for social service to provide medically-related social	



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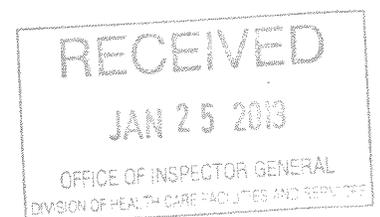
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F 250	<p>Continued From page 6</p> <p>Review of Resident #1's Minimum Data Set (MDS)s: dated 09/27/12 (Annual Assessment); 07/10/12 (quarterly assessment); and 02/02/12 (Admission Assessment); revealed Resident #1 was checked as having a communication problem, with no speech and was rarely or never understood.</p> <p>Observation of Resident #1, on 11/18/12 at 1:04 PM, revealed Resident #1 was able to move his/her head yes or no when asked a question, but unable to talk.</p> <p>Interview with Resident #1, on 11/18/12 at 1:04 PM, revealed he/she was "ok" by shaking his/her head yes and he/she could answer "no" when asked to shake his/her head "no".</p> <p>Observation of a Restorative treatment with Resident #1, on 11/19/12 at 9:33 AM, revealed the Restorative Aid requested the resident point to their hand and the resident was able to do so when asked.</p> <p>Interview with the Restorative Aid, on 11/19/12 at 9:25 AM, revealed she thought Resident #1 could use a communication board after Resident #1 showed her he/she could point to her hand.</p> <p>Record review of Resident #1's nurse's notes, dated 10/25/12 at 10:40 PM, revealed Resident #1 was having continuous screaming at the beginning of the shift. Routine Hydrocodone was administered per g-tube. Resident #1 then began screaming again late in the shift, routine pain medication was administered. Nurse's notes, dated 10/16/12 at 10:00 PM, revealed Resident #1 was crying out after routine pain medication</p>	F 250	<p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Social Service Director and the Social Service Assistant were inserviced on this new policy by the Administrator on 12-4-2012. On 11/21/2012 a Nursing/Social Service communication form was developed by the Director of Nursing to be utilized by nursing to keep Social Service informed of medically related psychosocial issues. On 12/03/2012 the Director of Nursing inserviced the Social Service Director, Unit A Coordinator and Unit B Coordinator on the use of the Nursing to Social Service Communication form. By 12/27/2012 all nursing staff will be inserviced by either the Staff Development Coordinator, Unit A Coordinator, Unit B Coordinator or Director of Nursing on the use of the Nursing/Social Service communication form.</p>		

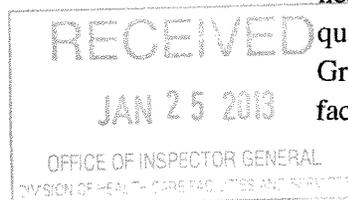
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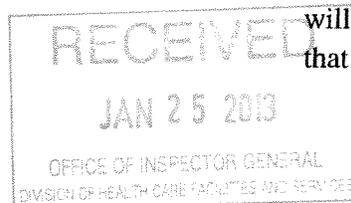
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F 250	<p>Continued From page 7</p> <p>and as needed pain medication was administered. The Certified Nursing Assistant (CNA) then went into the resident's room around 9:30 PM and turned on the television for Resident #1, no crying after the intervention. Nurse's notes, dated 09/25/12 at 8:30 PM, revealed Resident #1 had some crying out twice during the shift. The nurse noted the indwelling catheter was leaking. Resident #1 shook his/her head to feeling better when the catheter was adjusted. Nurse's notes, dated 09/26/12 at 1:00 AM, revealed staff attempted to reposition the resident; but, the resident continued to cry out. When asked if he/she was in pain the resident shook his/her head yes.</p> <p>Review of Resident #1's orders, dated November 2012, revealed Resident #1 was receiving Ativan routinely three (3) times a day for anxiety, since 04/30/12.</p> <p>Record review of the Speech Therapist notes revealed, Resident #1 was never assessed for a communication board.</p> <p>Interview with the Speech Language Pathologist (SLP), on 11/20/12 at 8:50 AM, revealed she had never assessed or seen Resident #1. The SLP stated she would need an order before she could evaluate Resident #1. The SLP stated no one had ever asked her to evaluate Resident #1's communication skills.</p> <p>Interview with Social Services, on 11/20/12 at 10:57 AM, revealed Resident #1 yelled like a baby, screamed almost and could not hold a conversation. Resident #1 loved to watch television, for people to be around him/her, for</p>	F 250	<p>4. On a weekly bases the Interdisciplinary Team will meet in the facility Standers of Care meeting to discuss each resident of the facility. At those meetings residents medically related social service needs will be presented and discussed. The Social Service Director will follow up with any identified social service needs for identified residents. Weekly the Interdisciplinary Care Plan team (MDS Nurse, Activity Director, Dietary Director, Facility Nurses, Social Service Director, and Therapy Representative) will meet to discuss scheduled residents plan of care. At that time the Social Service Director will make any changes or additions to the residents care plan. Starting 12/03/2012 the nursing department</p>		



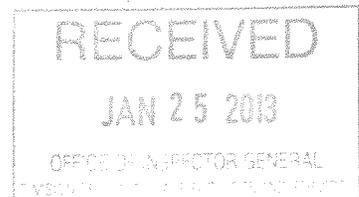
started utilizing the Nursing to Social Service Communication form. The form is designed to give nursing a way to communicate medically related social service needs to the Social Service Director. Monthly the Social Service Director will submit a report to the Quality Assurance Committee recapping the communication nursing made to Social Services over the past month. The Social Service Director will also supply the administrator with a recapping of the nursing to social service communication forms. The administrator will use the report to do a 10% random audit of residents care plans and social service notes to ensure the medically related social service needs have been addressed. Monthly the facility will hold a gradual dose reduction (GDR) meeting to review residents that are on Antidepressants and antipsychotic medications for the medications necessity. The GDR meeting will be attended by the Social Service Director, Director of Nursing, Administrator, Quality Assurance Nurse, Unit A and Unit B Coordinators, and the contracting pharmacist. Prior to the GDR meeting the pharmacist will have compiled a list of residents that need to have a GDR for this quarter. Parkview Psychiatric Group that contracts with the facility will also submit a



recommendation for GDRs for residents that are on their case load. All GDRs recommendations will be given to the resident's primary care physician for approval. Social Service and the Unit Coordinators will follow up with the recommendations to verify if the GDR was granted or not. If the GDR was denied the Social Service Director and Unit Coordinators will ensure proper documentation is in the resident medical record to support not doing a GDR. Those residents that were indentified for GDRs will be monitored by the specific residents nursing staff. Any noted behaviors related to the GDR or not having a GDR will be documented in the residents' behavior log and/or the resident's medical record. Three times a week the Social Service Director will review the behavior logs in order to capture any changes in the residents' behavior. Monthly the Social Service Director will submit a report to the Quality Assurance Committee addressing residents that were evaluated for a GDR, if the GDR was done, and the results of the GDR. Any resident noted as not being granted a GDR will be reviewed again in three (3) months by the GDR team for the possibility for a GDR related to antipsychotic and antidepressant medication use. The Quality Assurance Committee will keep a record of the residents that do not receive a recommended



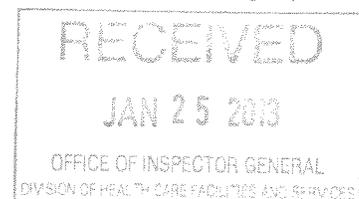
GDR and ask for an update from the GDR team every quarter during the Quality Assurance Meeting.



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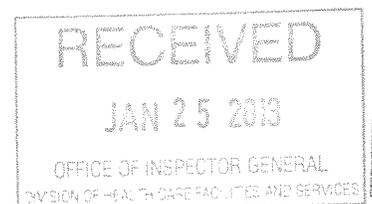
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F 250	Continued From page 8 people to talk to him/her and did not like to be alone. When staff ask him/her a question he/she would shake his/her head yes or no. The Social Services Director stated she never thought to see if Resident #1 could benefit from a communication board or for Resident #1 to be assessed for a communication board. When Resident #1 screamed out it could be that he/she wanted to watch television and that he/she was not anxious. The Social Services Director stated she attended meetings where they talked about medical conditions, behaviors and medications. She stated she was responsible to look at depression and anxiety. The Social Services Director stated she had been so busy and now that she had an assistant she would be able to catch up with her duties.	F 250	Completion Date: December 28, 2012	
F 279 SS=E	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	F 279	F 279 1. Resident #7 had a care plan developed on 12/10/2012 by the MDS Nurse for the use of antibiotics related to his/her bowel infection and MRSA. On 12/10/2012 Resident #7 had a care plan developed by the Wound Care Nurse related to the use of a wound vacuum. On 11/21/2012 a care plan was developed for Resident #7 by the Social Service Director related to his/her psychosocial needs while in isolation and her smoking practice. Resident #11 had a care plan developed for depression and the use of an antidepressant on 11/21/2012 by the Social Service Director. Resident #16 did not have a care plan for visual limitations developed because she did not trigger on her last three (3) quarterly MDS 3.0 assessments or her annual comprehensive	



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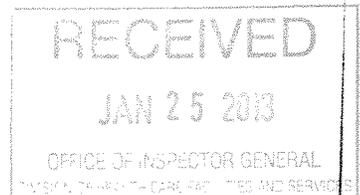
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F 279	<p>Continued From page 9 §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a comprehensive care plan for three (3) of nineteen (19) sampled residents and one (1) unsampled resident (Resident #7, # 11, and #16). Resident #7 required isolation for Methicillin- Resistant Staphylococcus Aureus (MRSA) in a wound, utilized a wound vacuum, was a smoker, received intravenous antibiotics, and was positive for Clostridium Difficile in the past. These issues were not addressed in the care plan. The facility failed to develop a care plan for depression for Resident #11 although it was triggered in the annual assessment and the Social Worker indicated in the Care Area Assessment (CAA) summary, the facility would proceed to care plan. The facility assessed Resident #16 with vision limitations but failed to develop a care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, undated, revealed the care plan would address the residents' problems.</p> <p>1. Observation of Resident #7, on 11/18/12 at 10:50 AM, revealed the facility had a sign posted outside the resident's room announcing Isolation/Contact Precautions were in effect.</p> <p>Review of the clinical record for Resident #7,</p>	F 279	<p>2. By utilizing the most recent MDS assessment on 11-21-2012 the Social Service Director with the help of the MDS Coordinator identified those residents who were in isolation, had a diagnoses of depression and who were on an antidepressant. Each of those residents was reviewed for appropriate care plans related to their identified medically related social service needs. Residents that were found to have inappropriate care plans or no care plan addressing the indentified issue was corrected by the Social Service Director on 11/21/2012. By 11/21/2012 all resident who have the diagnoses of depression and the use antidepressant medications were reviewed and updated by the Social Service Director. By 12/18/2012 the Social Service Director, Unit A Coordinator and the Unit B Coordinator will review each residents that is prescribed antidepressants for the appropriateness of the medication and the need for a Gradual Dose</p>		



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F 279	<p>Continued From page 10</p> <p>revealed the facility admitted the resident with diagnoses of Peripheral Artery Disease, Diabetes, Osteomyelitis and Post Amputation of the Left Toe with MRSA. The facility completed an admission Minimum Data Set (MDS) assessment on 10/31/12, the same day the resident was re-hospitalized for an amputation of the toe for gangrene and a bypass graph for poor circulation in the left leg. The MDS revealed the resident was cognitively intact, was a smoker, had no pressure areas and required extensive assistance with transfers, dressing and bathing. The facility readmitted the resident on 11/06/12 on antibiotics intravenously, with an unhealed foot wound contaminated with MRSA and required a wound vacuum and had a history of Clostridium Difficile in the stool during hospitalization.</p> <p>Review of the care plan for Resident #7, revealed a care plan for the wound was developed, however, the resident's isolation related to the MRSA, smoking, use of a wound vacuum. In addition, the resident had a history of recent infection for Clostridium Difficile. The use of antibiotics for treatment of the bowel infection and the wound were not care planned.</p> <p>Interview with MDS Coordinators #1 and #2, on 11/20/12 at 9:00 AM, revealed they missed these problems when developing the care plan for Resident #7. They stated they did review the clinical record; however, they did not think to address these issues.</p> <p>Interview with the Assistant Director of Nursing (ADON) #1, on 11/20/12 at 9:35 AM, revealed a care plan should have been developed to address Resident #7's isolation, smoking, wound</p>	F 279	<p>Reduction (GDR) if appropriate. Those residents identified as needing a GDR related to their antidepressant will have Parkview Psychiatric Services contacted on their behalf. With the GDR recommendation from Parkview and the Social Service Director, Unit A Coordinator or Unit B Coordinator the residents primary care physician will be notified.</p> <p>By 12/11/2012 the MDS nurses reviewed and updated each residents care plan that were in isolation. The MDS nurses reviewed the MDSs for all resident identified with vision impairments to ensure they had appropriate care plans, this was completed by 12/12/2012. There are no other residents at this time that utilize a wound vacuum.</p> <p>3. The facility policy for isolation related to MRSA was reviewed and updated on 12/12/2012 by the Administrator, Director of Nursing, Quality Assurance Nurse and Vice President of Operations. On 11/21/2012 the policy for</p>	



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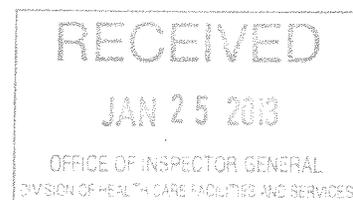
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F 279	<p>Continued From page 11 vacuum, antibiotics and recent/current infections.</p> <p>Interview with the Social Service Director, on 11/20/12 at 10:55 AM, revealed she did not realize Resident #7 was in isolation and she would have developed a care plan for isolation if she had known.</p> <p>Interview with the Administrator, on 11/20/12 at 2:00 PM, revealed a care plan regarding isolation should have been developed.</p> <p>2. Review of the medical record for Resident #11 revealed the facility admitted the resident on 11/07/07 with a diagnosis of Depression. Review of the medications for Resident #11 revealed the resident was taking an antidepressant prescribed since 05/12/2010.</p> <p>Review of the Annual Minimum Data Set Assessment (MDS), dated 04/12/12, revealed the facility assessed Resident #11 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The facility assessed the resident's mood with a total score of 2 with indications for feeling depressed, down, and hopeless 2 to 6 days during the Assessment reference date. Review of the Care Assessment Area (CAA), revealed the facility indicated the resident triggered for mood state and psychotropic drug use but did not indicate if a care plan was developed.</p> <p>Review of the CAA annual assessment summary for Resident #11, completed on 04/13/12 by the Social Worker, revealed a care plan would be developed as the facility assessed the resident</p>	F 279	<p>Clostridium Difficile was reviewed and updated by the Administrator and Vice President of Operations. By 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the proper way to document an isolation, when and who to place in isolation, and how to enter and exit an isolation resident room. The Social Service Director was inserviced on 12-4-2012 by the administrator on the importance of being aware of what is occurring with the residents in the facility. It is the responsibility of the Social Service Director to be aware of what residents are in isolation and what their psychosocial needs are related to being in isolation. On 11/21/2012 a Nursing/Social Service communication form was developed by the Director of Nursing to be utilized by nursing to keep Social Service informed of medically related psychosocial issues. On 12/03/2012 the Director</p>	
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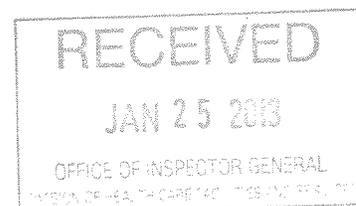
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F 279	<p>Continued From page 12 with minimal depression.</p> <p>Review of the care plan for Resident #11 revealed the facility did not develop a care plan to monitor for depression or side effects of the antidepressant.</p> <p>Interview with MDS Coordinator #1, on 11/20/12 at 9:20 AM, revealed the Social Worker was responsible for developing care plans for residents on psychotropic medications, related to cognition, mood and behavior.</p> <p>Interview with Social Services, on 11/20/12 at 11:00 AM, revealed the nurses responsible for the MDS assessments were doing all of the care plans but recently the facility had made a change and she was responsible for care plans for mood and behavior. She acknowledged Resident #11 should have had a care plan for depression with the annual assessment on 04/12/12 as the resident was on an antidepressant and triggered for mood state on the CAA. She stated she was responsible for knowing what the MDS indicated for mood and behavior for Resident #11.</p> <p>Interview with the the Administrator, on 11/20/12 at 3:30 PM, revealed the facility had identified problems with updating and developing care plans and were working on changing the policy on who was responsible for care plans. She stated the MDS nurses were doing most of the care plans but the care plans were not getting revised and updated.</p> <p>3. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 06/14/10 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Atherosclerosis,</p>	F 279	<p>of Nursing inserviced the Social Service Director, Unit A Coordinator and Unit B Coordinator on the use of the Nursing to Social Service Communication form. By 12/27/2012 all nursing staff will be inserviced by either the Staff Development Coordinator, Unit A Coordinator, Unit B Coordinator or Director of Nursing on the use of the Nursing/Social Service communication form.</p> <p>On 12/6/2012 the administrator inserviced the MDS nurses on the importance of being aware of what is addressed on the MDS and triggered in CAAs needs to be care plan. Also on 12/6/2012 the Administrator inserviced the MDS nurses on the importance of updating care plans in a timely manner and with the MDS assessment schedule. On 12/10/2012 the administrator inserviced the wound care nurse on the importance of adding new treatments such as a wound vacuum to the resident care plan.</p>	
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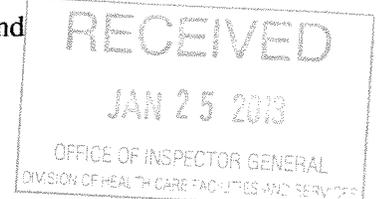
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F 279	Continued From page 13 Hypertension, Diabetes Type 2, Intracranial Hemorrhage, Reflux Esophagitis, and Constipation. Review of the Care Area Assessment Summary (CAAS), within the annual Minimum Data Set (MDS) assessment completed on 01/18/12, revealed Resident #16 triggered for Visual Function. Review of Resident #16's comprehensive care plan revealed the the resident did not have a care plan component for Visual Function. Interview, on 11/20/12, at 9:30 AM, with Licensed Practical Nurse (LPN) #1, Resident # 16's nurse, revealed she was not aware of what Resident #16's visual limitations were, and she did not know visual function was a triggered care area for Resident #16. Interview, on 11/20/12 at 11:00 AM, with MDS Coordinator #2 revealed Resident #16 triggered for Visual Function because he/she read large print, rather than small print, and wore corrective lenses. MDS Coordinator #2 stated every triggered area identified through the MDS assessment should be care planned. If the care plan was incomplete, then staff would not be able to adequately meet the resident's needs. In addition, MDS staff members were ultimately responsible for ensuring the care plans were complete, up-to-date, and accessible to staff at all times.	F 279	4. On a weekly bases the Interdisciplinary Team (Director of Nursing, Unit A & B Coordinators, Wound Care Nurse, Restorative Nurse, Social Services, Dietary Director, and Activities Director) will meet in the facility Standers of Care meeting to discuss each resident of the facility. At those meetings resident's medically		
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	F 280			

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related social service needs will be presented and discussed, and followed up by the Social Service Director. Weekly the Interdisciplinary Care Plan team will meet to discuss scheduled residents plan of care. At that time the Social Service Director, Activity Director, Dietary Manager, and MDS nurses will make any changes or additions to the residents care plan. Starting 12/03/2012 the nursing department started utilizing the Nursing to Social Service Communication form. The form is designed to give nursing a way to communicate medically related social service needs to the Social Service Director. Monthly the Social Service Director will submit a report to the Quality Assurance Committee recapping the communication nursing made to Social Services over the past month. The Social Service Director will also supply the administrator with a recapping of the nursing to social service communication forms. The administrator will use the report to do a 10% random audit of residents care plans and social service notes to ensure the medically related social service needs have been addressed.

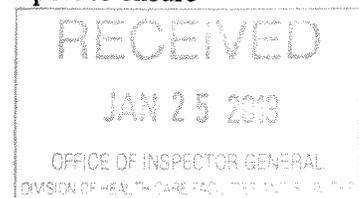
Monthly the facility will hold a gradual dose reduction (GDR) meeting to review residents that are on Antidepressants and



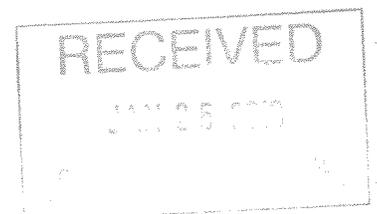
antipsychotic medications for their necessity. The GDR meeting will be attended by the Social Service Director, Director of Nursing, Administrator, Quality Assurance Nurse, Unit A and Unit B Coordinators, and the contracting pharmacist. Prior to the GDR meeting the pharmacist will have compiled a list of residents that need to have a GDR for this quarter. Parkview Psychiatric Group that contracts with the facility will also submit a recommendation for GDRs for residents that are on their case load. All GDRs recommendations will be given to the resident's primary care physician for approval. Social Service and the Unit Coordinators will follow up with the recommendations to verify if they were granted or not. If the GDR was denied the Social Service Director and Unit Coordinators will ensure proper documentation is in the resident medical record to support not doing a GDR. Monthly the Social Service Director will submit a report to the Quality Assurance Committee addressing residents that were evaluated for a GDR, if the GDR was done, and the results of the GDR. Any resident noted as not being granted a GDR will be reviewed again in three (3) months by the GDR team for the possibility for a GDR related to antipsychotic and antidepressant medication use.

The Quality Assurance Committee will keep a record of the residents that do not receive a recommended GDR and ask for an update from the GDR team every quarter during the Quality Assurance Meeting.

As Resident care issues arise that need to be added to the care plan the unit nurse will add an interim care plan to the residents working care plan. Daily the MDS nurses will receive a copy of the interim care plan that has been added to the resident's plan of care. When the MDS nurse updates the working care plan he/she will add the interim care plans to the current working care plan. Weekly the Director of Nursing will audit 10% of the residents care plans to ensure that they appropriately address the residents current care needs and have been updated in a timely manner. Monthly the Director of Nursing will submit his/her care plan audit to the Quality Assurance Committee for review. At any time the Director of Nursing finds an inappropriate care plan he/she will address the department that generated the care plan and ask for clarification. The Director of Nursing (DON) will submit a report of inappropriate care plans, who generated the care plan, and when the staff member was asked to clarify the care plan. The Quality Assurance (QA) Nurse will do an audit of the indentified care plans from the DONs report to ensure



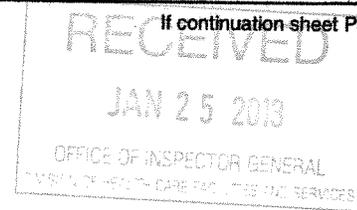
that the care plan issues was addressed appropriately by the facility staff member. Monthly the QA nurse will provide the QA committee with a report of his/her findings related to his/her audit of the indentified care plans from the DONs report. The QA committee will review this information for six months. After six months if the DON is no longer finding inappropriate care plans the QA committee will make the recommendation to decrease the DONs weekly audit to monthly. After the DONs care plan audit goes to monthly if at any time the QA committee if reported that 20% of care plans are found out of compliance the QA committee will make the recommendation to resume weekly audits by the DON. (With weekly or monthly audits the DON will continue to supply the QA nurse with an audit of the inappropriate care plans. The QA nurse will continue with her audit of the identified inappropriate care plans and his/her findings to the QA committee.)



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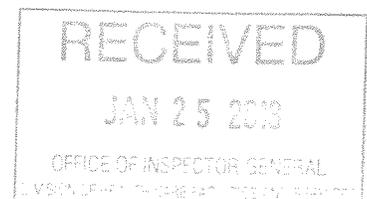
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2012
NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
(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 280	<p>Continued From page 14 changes in care and treatment.</p> <p>A comprehensive care plan must be developed 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, it was determined the facility failed to update the care plan for three (3) of nineteen (19) sampled residents and one (1) unsampled resident, Resident #1, #12 and #13. The facility failed to update the care plan for Resident #1 as it related to communication, failed to update the care plan for Resident #12 to address the death of his/her wife and failed to update the care plan for Resident #13 to address an infection.</p> <p>The findings include:</p> <p>1. Record review revealed there was no policy on care plans; however, the facility used the</p>	F 280	<p>Completion Date: December 28, 2012 F 280</p> <p>1. The communication care plan for Resident #1 was updated on 11/21/2012 by the Social Service Director to make it more individualized for his/her communication abilities and needs. On 11/21/2012 Speech Therapy evaluated and started treatment on Resident #1. On 11/21/2012 Social Services updated Residents #12's care plan by removing the approach "like to be involved in the care of his/her spouse". This was removed because Resident #12's spouse passed away. Resident #13's infection care plan was updated by the MDS nurse on 12/10/2012 to address he/she was positive for Clostridium Difficile.</p> <p>2. By 12/11/2012 the MDS nurses reviewed each residents care plan that were positive for Clostridium Difficile and updated any care plans as needed. The Social</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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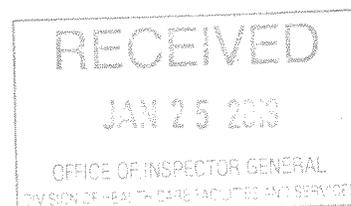
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F 280	<p>Continued From page 15</p> <p>Minimum Data Set (MDS) 3.0 for information on updating the care plan.</p> <p>Record review of Resident #1's Minimum Data Set (MDS)s: dated 09/27/12 (Annual Assessment); 07/10/12 (quarterly assessment); and 02/02/12 (Admission Assessment); revealed Resident #1 was checked as having a communication problem, with no speech and was rarely or never understood.</p> <p>Interview with the Social Services Director, on 11/20/12 10:57 AM, revealed Resident #1 liked to watch television, to be around people, for people to talk to him/her and to not be left alone.</p> <p>Record review of the communication care plan, dated 11/18/12, revealed the problem was impaired verbal communication related to a Stroke and Dysphasia. The Goal was to be able to communicate needs and feelings either through nonverbal actions or when asked yes or no questions. The approach stated staff would become familiar with nonverbal cues, gestures and body language. Staff would communicate with the resident by using yes or no questions. The care plan did not show any evidence of specific questions to ask to the likes and needs of the resident to ensure effective communication was achieved with the resident.</p> <p>Observation of Resident #1, on 11/18/12 at 1:04 PM, revealed Resident #1 lying in bed with his/her eyes open and appeared alert. When asked was he/she ok? Resident #1 was observed to shake his/her head yes. When asked could he/she shake his/her head no? Resident #1 was observed to shake his/her head no.</p>	F 280	<p>Service Director reviewed the care plans on 11/21/2012 of other residents who have or had spouses in the facility who were identified as "like to be involved in the care of his/her spouse", and updated the care plans as needed. On 11/21/2012 the Social Service Director reviewed the care plans of other residents that are identified as having communication needs and updated and individualized the care plans as necessary. On 12/05/2012 Speech Therapy screened other residents that were identified as having communication issues.</p> <p>3. On 11/21/2012 the Administrator, Director of Nursing, and Vice President of Operations agreed to continue to use the MDS 3.0 guidelines as the policy for care plans. On 11/21/2012 the facility policy for Clostridium Difficile was reviewed and updated by the</p>	



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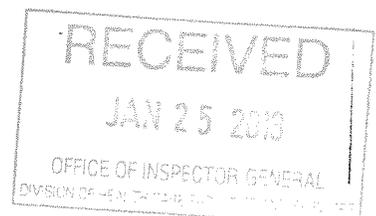
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F 280	Continued From page 16 Interview with the Minimum Data Set (MDS) Coordinator #2, on 11/20/12 at 3:01 PM, revealed she was not responsible for completion of the communication care plan. Social Services was. The MDS Coordinator #2 further stated she did not update the communication care plan, because she did not want to step on the Social Services toes. Interview with the Social Services Director, on 11/20/12 10:57 AM, revealed she was responsible for completing the communication care plan for Resident #1. The Social Services Director stated she did not think to place specific questions on the communication care plan to the likes and needs of the resident. Interview with the Assistant Director of Nursing (ADON) #2, on 11/19/12 at 10:17 AM, revealed she understood some of the care plans were not individualized to the resident. ADON #2 stated that about a month ago she began to implement the need to individualize the care plan and started on a few of the residents care plans, but had not gotten to all of them as of yet. ADON #2 said the care plans could be better. She stated it was everyone's responsibility to update the care plan. 2. Resident #12 was admitted to the facility on 04/26/07 with diagnoses of Hypertension, Coronary Artery Disease, Gout, Edema, Depression and a Pacemaker. Resident #12 was assessed by the facility as having no cognitive impairment on the MDS dated 11/16/12. Resident #12 had shared a room with his/her spouse until the spouse passed away last year.	F 280	Administrator and Vice President of Operations. On 12/11/2012 the facility policy on isolation was reviewed and updated by the Administrator, Director of Nursing, Vice President of Operations, and Quality Assurance Nurse. By 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the proper way to document an isolation, when and who to place in isolation, and how to enter and exit an isolation resident room. The Social Service Director was inserviced on 12-4-2012 by the administrator on the importance of being aware of what is occurring with the residents in the facility. It is the responsibility of the Social Service Director to be aware of what residents are in isolation and what their psychosocial needs are related to being in isolation. On	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	Continued From page 17 Record review of the care plan for Resident #12 under "Approach" listed the resident and his/her spouse as roommates and Resident #12 liked to be involved in the care of his/her spouse. The begin date noted on the approach was 06/28/10. There was no end date on the care plan. The care plan had not been updated since the spouse passed away. Interview, on 11/20/12 at 11:20 AM, with the Assistant Director of Nursing (ADON) on Unit B revealed a new system was being put in place to update the care plans. She stated it was intended for nurses to update the care plan by adding changes in the resident's condition, changes in medications, new orders and activities of daily living (ADL) decline. She stated it was not acceptable to have a change from over a year ago not updated on the care plan. She revealed the MDS nurse monitored the care plan for accuracy and it was the MDS nurse who was responsible for the updates. Interview, on 11/20/12 at 11:25 AM, with the Director of Nursing (DON) revealed a new policy was just implemented two (2) to three (3) weeks ago to update the care plans. However, a new care plan policy was not submitted to the survey team when the care plan policy was requested. The care plan of Resident #12, she stated should have been updated to reflect the passing of the spouse.	F 280	11/21/2012 a Nursing/Social Service communication form was developed by the Director of Nursing to be utilized by nursing to keep Social Service informed of medically related psychosocial issues. On 12/03/2012 the Director of Nursing inserviced the Social Service Director, Unit A Coordinator and Unit B Coordinator on the use of the Nursing to Social Service Communication form. By 12/27/2012 all nursing staff will be inserviced by either the Staff Development Coordinator, Unit A Coordinator, Unit B Coordinator or Director of Nursing on the use of the Nursing/Social Service communication form. On 12/6/2012 the administrator inserviced the MDS nurses on the importance of being aware of what is addressed on the MDS and triggered in CAAs needs to be care plan. Also on 12/6/2012 the administrator inserviced the MDS nurses on the importance of updating care plans in a timely manner.		



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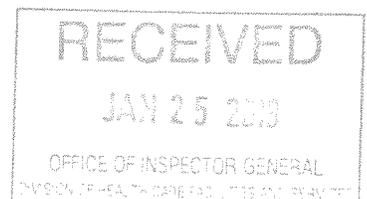
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F 280	<p>Continued From page 18</p> <p>3. Review of Resident #13's clinical record revealed the facility admitted the resident on 06/20/12 with a diagnosis of Dementia. The facility completed a quarterly Minimum Data Set (MDS) assessment on 10/6/12. The MDS revealed the resident was cognitively impaired with a Brief Interview Mental Status (BIMS) score of four (4) and was also incontinent. Lab results, dated 11/15/12 and 11/16/12, revealed the resident was positive for Clostridium Difficile (C-Diff).</p> <p>Review of the comprehensive care plan, dated 06/20/12 and revised 10/02/12, revealed C-Diff was not included on the infection care plan. There was no identification of contact precautions, including the need to use Personal Protective Equipment (PPE) of gown and gloves when entering the resident's room. Interventions included assist the resident to the toilet and observe for signs or symptoms of urinary tract infection.</p> <p>Interview, on 11/19/12 at 11:25 AM, with the Administrator revealed resident care plans were not individualized for residents. The Administrator stated he/she knew there were problems with the residents care plans.</p> <p>Observation, on 11/19/12 at 3:10 PM, revealed a sign on the resident's door that indicated contact precautions. A cart outside the resident's door contained PPE gowns and gloves.</p> <p>Interview with the Assistant Director of Nursing (ADON) for the B Unit, on 11/19/12 at 3:50 PM, revealed C-Diff was included on resident care plans. The ADON stated he/she was responsible</p>	F 280	<p>4. . On a weekly bases the Interdisciplinary Team (Director of Nursing, Unit A & B Coordinators, Wound Care Nurse, Restorative Nurse, Social Services, Dietary Director, and Activities Director) will meet in the facility Standers of Care meeting to discuss each resident of the facility. At those meetings resident's medically related social service needs will be presented and discussed and followed up by the Social Service Director. Weekly the Interdisciplinary Care Plan team will meet to discuss scheduled residents plan of care. At that time the Social Service Director, Activity Director, Dietary Manager, and MDS nurses will make any changes or additions to the residents care plan. Starting 12/03/2012 the nursing department started utilizing the Nursing to Social Service Communication form. The form is designed to give nursing a way to communicate medically related social service needs to the Social Service</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

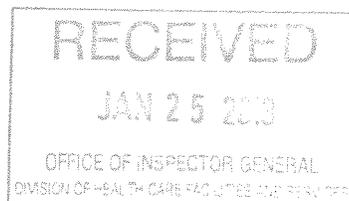
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F 280	Continued From page 19 to update resident care plans. Interview, on 11/20/12 at 10:15 AM, with the Unit Secretary for the B Unit revealed C-Diff should have been included on Resident #1's care plan. The Unit Secretary reported the ADON was responsible to update the care plan to include C-Diff. On 11/20/12 at 10:20 AM, interview with Registered Nurse (RN) #1 revealed C-Diff was not on the care plan for Resident #13. The RN stated he/she would be aware if residents were on contact precautions only from the shift report.	F 280	Director. Monthly the Social Service Director will submit a report to the Quality Assurance Committee recapping the communication nursing made to Social Services over the past month. The Social Service Director will also supply the administrator with a recapping of the nursing to social service communication forms. The administrator will use the report to do a 10% random audit of residents care plans and social service notes to ensure the medically related social service needs have been addressed. Monthly the facility will hold a gradual dose reduction (GDR) meeting to review residents		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to identify isolation/contact precautions for one (1) of nineteen (19) sampled residents and one (1) unsampled resident (Resident #8) on the initial care plan. Resident #8 was admitted by the facility and required isolation/contact precautions related to a bowel infection. The findings include: Interview with the Assistant Director of Nursing (ADON), on 11/20/12 at 9:35 AM, revealed the facility had no policy for completion of an initial	F 281			



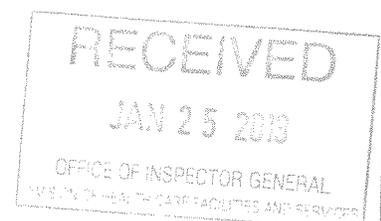
that are on Antidepressants and antipsychotic medications for their necessity. The GDR meeting will be attended by the Social Service Director, Director of Nursing, Administrator, Quality Assurance Nurse, Unit A and Unit B Coordinators, and the contracting pharmacist. Prior to the GDR meeting the pharmacist will have compiled a list of residents that need to have a GDR for this quarter. Parkview Psychiatric Group that contracts with the facility will also submit a recommendation for GDRs for residents that are on their case load. All GDRs recommendations will be given to the resident's primary care physician for approval. Social Service and the Unit Coordinators will follow up with the recommendations to verify if they were granted or not. If the GDR was denied the Social Service Director and Unit Coordinators will ensure proper documentation is in the resident medical record to support not doing a GDR.

As Resident care issues arise that need to be added to the care plan the unit nurse will add an interim care plan to the residents working care plan. Daily the MDS nurses will receive a copy of the interim care plan that has been added to the residents plan of care. When the MDS nurse updates the working care plan he/she will add the interim care plans to the current



working care plan. Weekly the Director of Nursing will audit 10% of the residents care plans to ensure that they appropriately address the residents current care needs and have been updated in a timely manner. Monthly the Director of Nursing will submit his/her care plan audit to the Quality Assurance Committee for review. At any time the Director of Nursing finds an inappropriate care plan he/she will address the department that generated the care plan and ask for clarification. The Director of Nursing (DON) will submit a report of inappropriate care plans, who generated the care plan, and when the staff member was asked to clarify the care plan. The Quality Assurance Nurse will do an audit of the identified care plans in the DONs report to ensure that the care plan issues was addressed appropriately by the facility staff member.

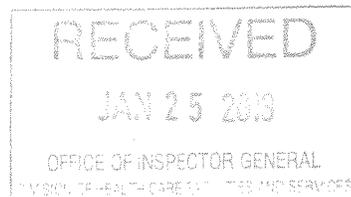
On a monthly bases following the MDS assessment schedule Speech Therapy will screen residents to identify a need for communication therapy. The Speech Therapist will submit a report to the Quality Assurance Committee of the residents that were screened, evaluated and then started on a plan of care as a result of a communication need.



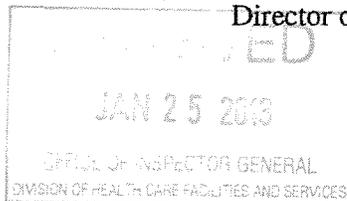
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F 281	Continued From page 20 care plan to be used until the comprehensive care plan was developed; however, the expectation was that an initial care plan would be completed. Review of the clinical record for Resident #8, revealed the facility admitted the resident with a diagnosis of Clostridium Difficile Infection. The facility developed an initial care plan, on 11/12/12, which did not include isolation of Resident #8 related to a bowel infection. Interview with Licensed Practical Nurse (LPN) #8, on 11/19/12 at 9:00 AM, revealed the admitting nurse started an initial nursing care plan to provide care to the resident. She stated isolation was an important part of the care plan for this resident and ensured the resident's bowel infection would not be spread to other residents. Interview with the ADON, on 11/20/12 at 9:35 AM, revealed isolation should have been included in Resident #8's initial care plan.	F 281	Completion Date: December 28, 2012 F 281 1. On 12/10/2012 a care plan was developed for Resident #8 by the MDS nurse related to isolation for Clostridium Difficile. 2. By 12/11/2012 the MDS nurses reviewed each residents care plan that were positive for Clostridium Difficile and updated their care plans to include isolation.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309			

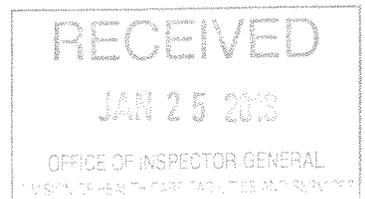


3. On 11/21/2012 the facility policy for Clostridium Difficile was reviewed and updated by the Administrator and Vice President of Operations. On 12/11/2012 the facility policy on isolation was reviewed and updated by the Administrator, Director of Nursing, Vice President of Operations, and Quality Assurance Nurse. By 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the proper way to document an isolation, when and who to place in isolation, and how to enter and exit an isolation resident room. On 12/6/2012 the administrator inserviced the MDS nurse on the importance of updating care plans in a timely manner. On 12/10/2012 the Unit Coordinators for Unit A and B were inserviced by the Director of Nursing on a tool that



would assist with developing an initial isolation care plan that could be placed in the residents working care plan.

4. On 12/10/2012 the Unit Coordinators for Unit A and B were supplied with a tool that would assist with developing an isolation infection care plan. Daily the MDS nurses will receive a copy of the interim care plan that has been added to the resident's plan of care. When the MDS nurse updates the working care plan he/she will add the interim care plans to the current working care plan. Weekly the Director of Nursing will audit 10% of the residents care plans to ensure that they have been updated in a timely manner. Monthly the Director of Nursing will submit his/her care plan audit to the Quality Assurance Committee for review.



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CENTERS FOR MEDICARE & MEDICAID SERVICES

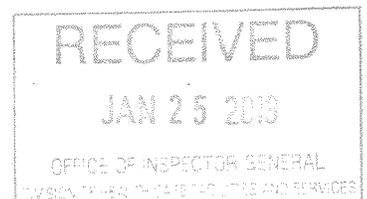
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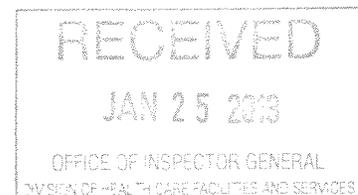
F 309	<p>Continued From page 21</p> <p>Based on interview, record review and facility policy, it was determined the facility failed to follow orders from the Advanced Practice Registered Nurse (APRN) for one (1) of nineteen (19) sampled residents and one (1) unsampled resident (Resident #8) The facility failed to follow the APRN's order to transfer the resident to a private room for isolation/contact precautions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy for Physician Orders, undated, revealed the facility would not give any treatment to a resident unless ordered by a physician or other licensed health professional. <p>Review of the facility policy's for Contact Precautions, dated 12/04/08, revealed Clostridium Difficile infections would be placed in a private room, especially residents with fecal incontinence. Residents who have symptoms of the infection may be placed in the same room.</p> <p>Observation of Resident #8, on 11/18/12 at 11:00 AM, revealed the resident in an occupied semi-private room.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident on 11/12/12 with diagnoses of Recurrent Clostridium Difficile Colitis and Protein Malnutrition. The resident was admitted to a semi-private room with another resident. The initial care plan indicated the resident was incontinent of bowel. The resident was placed in contact precautions/isolation related to the diagnosis of colitis. On 11/13/12, the APRN ordered the</p>	F 309	<p>Completion Date: December 28, 2012 F 309</p> <ol style="list-style-type: none"> On 11/23/2012 the physician order to have Resident #8 was carried out and Resident #8 was moved into a room without a roommate. On 11/21/2012 a screen was put into Speech Therapy by nursing to evaluate and treat Resident #1 related to her communication needs/abilities. Resident #1 was evaluated and is receiving treatment from the Speech Therapist. On 11/23/2012 the Unit Coordinators for Unit A and B evaluated each resident that was currently in isolation to ensure they were either in isolation or moved to isolation if they did not met the criteria to be in a room with another resident. The residents that were in isolation also had their physician orders reviewed to ensure the physician orders were being carried out correctly. By using the 	
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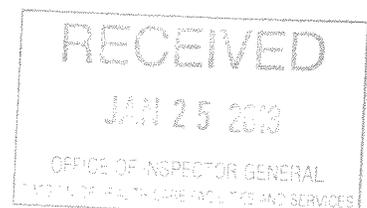
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2012
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F 309	<p>Continued From page 22</p> <p>resident be moved to an empty room for isolation. The resident was moved then returned to the original semi-private room.</p> <p>Review of the clinical record revealed no documentation of an order to cancel the resident's move to an empty room.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 11/19/12 at 11:00 AM, revealed Resident #8 was in the same room as Resident #7 since Resident #7 had a past history of clostridium difficile colitis. She stated Resident #7 did not currently have the infection and recent cultures were negative for the infection. She stated the APRN should have been notified that Resident #8 was not moved to an empty room and was not able to provide documentation of a notification.</p> <p>Interview with the ADON, on 11/20/12 at 10:20 AM, revealed the decision to move Resident #8 out of the private room back into the room with Resident #7 was made since the empty room bathroom was shared with another room. She stated Resident #8 and Resident #7 were both provided with bedside commodes and did not offer an explanation for why the shared bathroom would have made a difference if the resident used a bedside commode. She could not say if the APRN was notified that the order was not followed. She stated the normal practice was to notify a physician if an order was not followed.</p> <p>Interview with the APRN, on 11/20/12 at 3:00 PM, revealed he was not aware Resident #8 was not moved to an empty room. He stated he was the APRN for both Resident #7 and Resident #8. He revealed he was concerned about Resident #7</p>	F 309	<p>most recent MDS assessment, on 11-21-2012 the Social Service Director with the help of the MDS Coordinator identified those residents who had communication issues, and those residents were screened by Speech Therapy. By 12/05/2012 Speech Therapy had screen other residents that were identified as having communication issues.</p> <p>3. On 11/21/2012 the policy for Clostridium Difficile was reviewed and updated by the Administrator and Vice President of Operations. On 12/03/2012 the Unit Coordinators for A Unit and B Unit, the 2nd shift Supervisor, and the Third shift Supervisor were inserviced by the Director of Nursing on the importance of following APRN's and Physician orders. By 12/27/2012 all nurses were inserviced by either the Director of Nursing or Staff Development Coordinator on the importance of following APRN's and Physician orders.</p>		



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F 309	<p>Continued From page 23</p> <p>developing another infection from Resident #8. He stated Resident #7 had a serious infection in a wound and osteomyelitis and could not afford to be re-infected with clostridium difficile. He state this was the reason he ordered Resident #8's moved to an empty room.</p> <p>2. Record review of Resident #1, revealed the facility admitted the resident on 01/26/12 with a diagnoses of Diabetes Mellitus 2, Dysphagia (difficulty swallowing), Renal (Kidney) Failure, Cerebral Vascular Accident, Hypertension, Depression, Psychosis, Anxiety, Gastro Tube Placement, Multiple Contractures.</p> <p>Observation of Resident #1, on 11/18/12 at 1:04 PM, revealed Resident #1 lying in bed with his/her eyes open and appeared alert. When asked if he/she was ok? Resident #1 was observed to shake his/her head yes. When asked could he/she shake his/her head no? Resident #1 was observed to shake his/her head no.</p> <p>Review of Resident #1's the Minimum Data Set (MDS)s: dated 09/27/12 (Annual Assessment); 07/10/12 (quarterly assessment); and 02/02/12 (Admission Assessment); revealed Resident #1 was checked as having a communication problem, with no speech and was rarely or never understood.</p> <p>Record review of Resident #1's Nurse's notes dated 10/16/12 at 10:00 PM, revealed Resident #1 was crying out after routine pain medication and as needed pain medication was administered. The Certified Nursing Assistant (CNA) then went into the resident's room around 9:30 PM and turned on the television for Resident</p>	F 309	<p>By 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the proper way to document an isolation, when and who to place in isolation, and how to enter and exit an isolation resident room.</p> <p>On 12/12/2012 the Speech Therapist was inserviced by the administrator that she does not have to wait for facility staff to ask for an evaluation of a resident. That as a Speech Therapist if he/she sees a need for a resident as a clinician he/she can request orders for that resident. By 12/27/2012 facility nurses will be inserviced by the Director of</p>		



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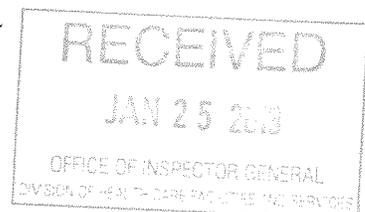
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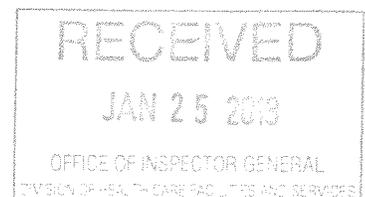
F 309	<p>Continued From page 24 #1, no crying after the adjustment.</p> <p>Interview with Social Services on, 11/20/12 at 10:57 AM, revealed Resident #1 loved to watch television, talk to people and not be alone. When asked how do the staff know what to ask Resident #1 when he/she yelled out, Social Services stated she did not think to educate the staff on the need for communication nor think to place on the care plan specific questions to help the staff communicate effectively. The Social Services Director stated it was ultimately the facility's responsibility to take care of the resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 11/19/12 3:25 PM, revealed when Resident #1 yelled out, CNA #8 would see if Resident #1 needed a brief change or was comfortable. CNA #8 stated Resident #1 would respond by nodding his/her head yes or no. Resident #1 liked to listen to the Spanish radio and watch television. CNA #8 stated she never thought of enquiring about a communication board. Resident #1 could benefit from a communication board especially if he/she could communicate effectivity.</p> <p>Observation of a Restorative treatment with Resident #1, on 11/19/12 at 9:33 AM, revealed Resident #1 was able to point to the Restorative Aids hand when asked.</p> <p>Interview with the Restorative Aid, on 11/19/12 at 9:25 AM, revealed she thought Resident #1 could use a communication board after Resident #1 showed her he/she could point to her hand.</p> <p>Interview with Licensed Practical Nurse (LPN) #5,</p>	F 309	<p>Nursing or Staff Development Coordinator on the importance of providing and directing care for residents so that they meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>The Social Service Director was also inserviced by the administrator on 11/20/2012 the importance of looking at each resident as an individual, and to include other disciplines opinions/input into the care needs of the residents. Such the case with resident #1 the Social Service Director was encouraged to find ways to promote the highest practicable physical, mental, and psychosocial well-being for that resident and each resident in the facility. On 12-3-2012 a social service policy was created and implemented. The policy covered the necessity for social service to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-</p>	
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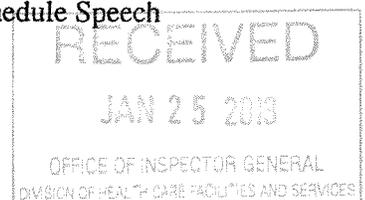
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F 309	Continued From page 25 on 11/20/12 at 9:09 AM, revealed when Resident #1 yelled and cried out, the nurse would ask her if she was sad. LPN #5 stated just because Resident #1 yells, does not mean he/she needed a pain medication. LPN #5 stated she did ask Resident #1 if he/she needed a brief change and was he/she in pain. LPN #5 stated she never thought to ask about a communication board and has never brought it to the attention of the physician for an evaluation of a communication board. Interview with the Speech Language Pathologist (SLP), on 11/20/12 at 8:50 AM, revealed she had never assessed or seen Resident #1. The SLP stated she would need an order before she could evaluate Resident #1. The SLP stated no one had ever asked her to evaluate Resident #1's communication skills. Interview with the Assistant Director of Nursing (ADON) #2, on 11/20/12 at 3:10 PM, revealed she informed the nurses when providing care to ask Resident #1 if she need anything. She encouraged the nurses to document what they did and the effectiveness. When ADON #2 was asked how do staff know what key questions to ask Resident #1 about his/her care, ADON #2 stated unfortunately their was a care plan issue and felt like Resident #1 was not at his/her highest level when it came to communication.	F 309	being of each resident. The Social Service Director and the Social Service Assistant were inserviced on this new policy by the Administrator on 12-4-2012. On 11/21/2012 a Nursing/Social Service communication form was developed by the Director of Nursing to be utilized by nursing to keep Social Service informed of medically related psychosocial issues. On 12/03/2012 the Director of Nursing inserviced the Social Service Director, Unit A Coordinator and Unit B Coordinator on the use of the Nursing to Social Service Communication form. By 12/27/2012 all nursing staff will be inserviced by either the Staff Development Coordinator, Unit A Coordinator, Unit B Coordinator or Director of Nursing on the use of the Nursing/Social Service communication form.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329			



4. Daily the Unit Coordinators for Unit A and Unit B receive a copy of all Physician/ARNP orders written in the last 24 hours. The Unit coordinators will ensure that Physician/ARNP orders written for isolation are followed. Daily the Director of Nursing receives a copy of all Physician/ARNP orders written in the last 24 hours. The Director of Nursing will follow up with the Unit Coordinators to ensure Physician/ARNP orders for isolation have been followed. On the week-ends the Week-end supervisor will review Physician/ARNP orders to ensure isolation orders are followed. Monthly the Infection Control nurse will submit a report identify if residents were in isolation and if the Physician/ARNP order was received and followed.

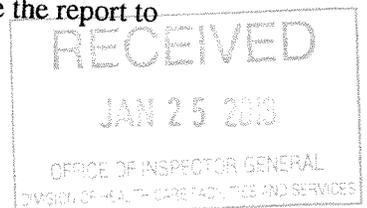
On a monthly bases following the MDS assessment schedule Speech



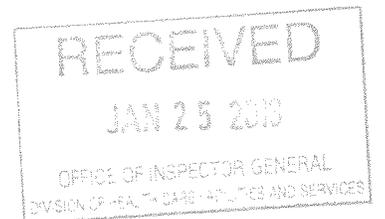
Therapy will screen residents to identify a need for communication therapy. The Speech Therapist will submit a report to the Quality Assurance Committee of the residents that were screened, evaluated and started on a plan of care as a result of a communication need.

As of 12/27/2012 Certified Nursing Assistance have been give a tool to use as communication to nurse that are caring for residents. The communication tools are a way to identify changes with residents. Monthly the Quality Assurance Nurse will supply the Director of Nursing with a report of the utilization and effectiveness of the communication tool.

Starting 12/03/2012 the nursing department started utilizing the Nursing to Social Service Communication form. The form is designed to give nursing a way to communicate medically related social service needs to the Social Service Director. Monthly the Social Service Director will submit a report to the Quality Assurance Committee recapping the communication nursing made to Social Services over the past month. The Social Service Director will also supply the administrator with a recapping of the nursing to social service communication forms. The administrator will use the report to



do a 10% random audit of residents
care plans and social service notes
to ensure the medically related
social service needs have been
addressed.



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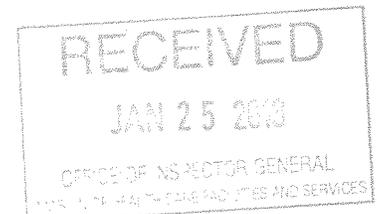
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F 329	<p>Continued From page 26 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure two (2) of nineteen (19) sampled residents and one (1) unsampled resident were assessed for a medication reduction as required. (Residents #1 and #11).</p> <p>The findings include:</p> <p>1. Review of the facility's Pharmacy Recommendation Policy, effective dated 01/06, revealed all pharmacy recommendations will be responded to in a timely manner. Timely manner in this facility would be defined as within ten</p>	F 329	<p>Completion Date: December 28, 2012 F 329</p> <p>1. Resident #1 had her medications reviewed by Parkview Psychiatric Services on 11/21/2012 for a Gradual Dose Reduction related to the use of Ativan (Anti-anxiety medication). The physician order was for 11/21/2012 0.51 Ativan three times a day (TID) for thirty (30) days per G-tube and then two times a day (BID). On 12/13/2012 Resident #1's Antidepressant was reviewed by the Pharmacy and Parkview Psychiatric Services and it was decided to not do a Gradual Dose Reduction on her at this time. Currently the resident is getting the lowest doses of the prescribed medication and she is not showing any signs or symptoms of depression thus the medication is indicated as appropriate.</p>	
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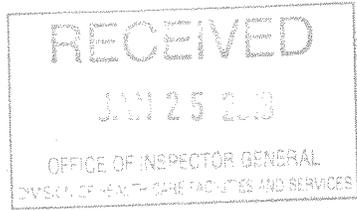
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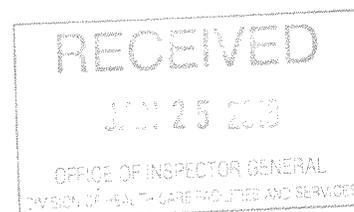
F 329	<p>Continued From page 27 physician working days of receipt of the recommendation.</p> <p>Record review of Resident #1's orders, dated 11/12, revealed Resident #1 was receiving routine Ativan (Anti-anxiety medication) 1 mg three (3) times a day since 04/30/12.</p> <p>Observations of Resident #1, on 11/18/12 at 11:20 AM, 11/18/12 at 1:04 PM, 11/18/12 at 1:50 PM, 11/19/12 at 8:16 AM, 11/19/12 at 9:33 AM, 11/19/12 at 10:34 AM, 11/19/12 at 11:44 AM and 11/19/12 at 3:18 PM, revealed the resident did not appear anxious in any way.</p> <p>Interview with the Hipaa Consultant Pharmacist, on 11/20/12 on 1:50 PM, revealed Gradual Drug reductions (GDR)'s were to occur within two (2) consecutive quarters at least a month apart. If a patient lived in the facility a couple of years then they would try to do a GDR at least once a year. The Hipaa Consultant Pharmacist was aware the facility did not have a Psychiatric Consult Group to render services for a couple of months. The Hipaa Consultant Pharmacist stated the facility was making recommendations but 90% of the recommendations were denied. The Hipaa Consultant Pharmacist stated they made recommendations not only for anti-psychotic medications but for anti-anxiety too. When making recommendations we look at behavior logs and nursing notes. The Hipaa Consultant Pharmacist finally stated it was the goal to reduce the anti-psychotic drug usage first and foremost.</p> <p>Review of the Consultant Pharmacist Communication to Physicians, dated 08/13/2012,</p>	F 329	<p>2. By 12/18/2012 the Social Service Director, Unit A Coordinator and the Unit B Coordinator will review each residents that is prescribed antidepressants, anti-anxiety and antipsychotic medications for the appropriateness of the medication and the need for a Gradual Dose Reduction (GDR) if appropriate. Those residents identified as needing a GDR related to their antidepressant anti-anxiety and antipsychotic medications will have Parkview contacted on their behalf. With the GDR recommendation from Parkview and the Social Service Director, Unit A Coordinator or Unit B Coordinator the residents primary care physician will be notified.</p> <p>3. On 12/14/2012 the Administrator, Director of Nursing and Social Service Director reviewed and updated the facility Pharmacy Recommendation Policy.</p>	
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F 329	<p>Continued From page 28</p> <p>revealed Resident #1 was recommended for a GDR for the drug Ativan ordered in April 2012; however, the communication form was left blank and not acknowledged.</p> <p>Interview with the Assistant Director of Nursing (ADON) #2, on 11/19/12 10:17 AM, revealed when the facility lost their psych consulting physician services, the facility was dependent on the Pharmacist to review psychotropic medications. ADON #2 stated the pharmacists were trying to get the facility caught up with the resident reviews. ADON #2 stated the Pharmacist reviewed the psychotropic medications and then coordinated with the ADON and was then coordinated the Doctor. Interview with ADON #2, on 11/20/12 3:10 PM, revealed upon her own record review she could not find anything documented to prove the need for the Ativan medication.</p> <p>Record review of the Resident #1's Behavior logs for the months of August, September and November 2012, revealed no behaviors were documented.</p> <p>Interview with ADON #2, on 11/20/12 at 3:10 PM, revealed no other behavior logs for Resident #1 could be found. ADON #2 stated she had not received any GDR's for Resident #1 as it related to the Ativan medication and was not aware the Pharmacist had given her a Communication form with the request of a GDR for Resident #1. The ADON stated she did not think Resident #1 was at his/her highest potential and called the Practitioner to inform her that Resident #1 did not have any documented need for the Ativan.</p>	F 329	<p>On 12/12/2012 the Administrator, Director of Nursing, Quality Assurance Nurse, Unit Coordinators for Unit A & B, and Social Service Director were inserviced by the Consultant Pharmacist on the importance and reasoning for gradual dose reductions. On 12/12/2012 the Administrator, Social Service Director, Director of Nursing and Consultant Pharmacist reviewed the guidelines for the recently established GDR meeting, and made some updates to include input from the Contracted Psychiatric Group. The GDR meeting is held monthly and reviews a third of the facility residents at the meeting.</p> <p>4. Monthly the facility will hold a gradual dose reduction (GDR) meeting to review a third of the residents that are on antidepressants, anti-anxiety and antipsychotic medications for the medications necessity. (Within a quarter all residents will be seen through the GDR meetings.) The</p>		



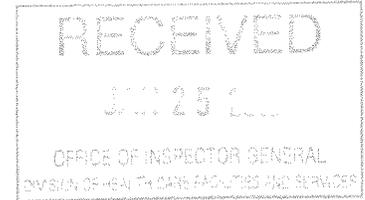
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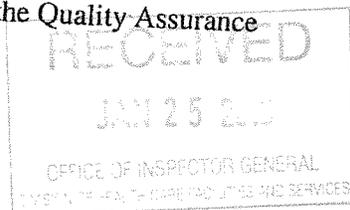
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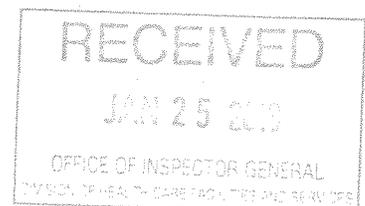
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F 329	<p>Continued From page 29</p> <p>Interview with the Administrator, on 11/20/12 4:00 PM, revealed although there was no psychiatrist, reviews of medication and GDR's still have to occur for the residents.</p> <p>2. Review of the medical record for Resident #11 revealed the facility admitted the resident on 11/07/07 with a diagnosis of Depression. Review of the medications for Resident #11 revealed the resident was taking an antidepressant prescribed since 05/12/10.</p> <p>Review of the monthly Pharmacy review for Resident #11 from 08/02/11 until 11/07/12 revealed no recommendation for a Gradual Dose Reduction (GDR) for the use of an antidepressant.</p> <p>Interview with ADON #2, on 11/20/12 at 9:20 AM, revealed the facility was without a Psychiatric Consulting Physician until recently. She stated the Monthly Pharmacy review was an integral part in the GDR for residents in the facility.</p> <p>Interview with the Consultant Pharmacist, on 11/20/12 at 1:45 PM, revealed the consultant group was aware the facility did not have a Psychiatric Consulting Physician for several months to assist with GDR for residents on psychotropic medications. He did acknowledge for residents on any psychotropic medications they should have a GDR for two consecutive quarters at least one month apart if the resident was started on a new medication or admitted on a psychotropic medication, then the GDR should be attempted annually. He stated the Director of Nursing (DON) put together a monthly meeting, 2-3 months ago, with the pharmacy to address</p>	F 329	<p>GDR meeting will be attended by the Social Service Director, Director of Nursing, Administrator, Quality Assurance Nurse, Unit A and Unit B Coordinators, and the contracting pharmacist. Prior to the GDR meeting the pharmacist will have compiled a list of residents that need to have a GDR for this quarter. Parkview Psychiatric Group that contracts with the facility will also submit a recommendation for GDRs for residents that are on their case load. All GDRs recommendations will be given to the resident's primary care physician for approval. Social Service and the Unit Coordinators will follow up with the recommendations to verify if the GDR was granted or not. If the GDR was denied the Social Service Director and Unit Coordinators will ensure proper documentation is in the resident medical record to support not doing a GDR. Those residents that were indentified for GDRs will be monitored by the</p>	



specific residents nursing staff. Any noted behaviors related to the GDR or not having a GDR will be documented in the residents' behavior log and/or the resident's medical record. Three times a week the Social Service Director will review the behavior logs in order to capture any changes in the residents' behavior. Monthly the Social Service Director will submit a report to the Quality Assurance



Committee addressing residents that were evaluated for a GDR, if the GDR was done, and the results of the GDR. Any resident noted as not being granted a GDR will be reviewed again in three (3) months by the GDR team for the possibility for a GDR related to antipsychotic and antidepressant medication use. The Quality Assurance Committee will keep a record of the residents that do not receive a recommended GDR and ask for an update from the GDR team every quarter during the Quality Assurance Meeting.



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

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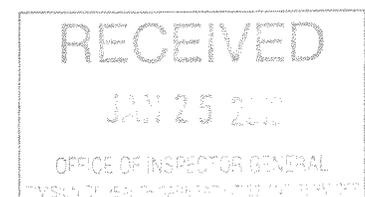
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F 329	Continued From page 30 GDR for patients on psychoactive medications. He stated they started with 2 hallways a month and with residents who were on multiple psychotropic medications. He stated residents who were on only one psychotropic medication and at a low dose were not a high priority. He did acknowledge Resident #11 should have had a review of the antidepressant at least annually.	F 329	Completion Date: December 28, 2012	
F 371 SS=F	483.35(i) 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 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure three (3) of five (5) staff used hand hygiene during the noon meals on 11/18/12 and 11/19/12. Nursing staff were observed going from resident to resident providing care without hand hygiene. One (1) employee was observed removing a cloth from a bucket of sanitizer and wiping her hands with the rag. The findings include: Review of the facility's policy regarding Hand Washing, undated, revealed employees were to	F 371	1. No specific residents were identified to been affected by the deficient practice. 2. Any resident that eats in the dining room had a potential to be affected by the same deficient practice. 3. The facility policy regarding Hand Washing was reviewed and updated by the Administrator, Director of Nursing and Infection Control Nurse on 12/04/2012. On 12/07/2012 the Dietary staff was inserviced by the Dietary Managers on the appropriate technique and the appropriate time for dietary staff to perform hand washing. On 12/07/2012 the Dietary staff was inserviced by the Dietary Manager to never use the red sanitizer buckets in dietary for the purpose of	

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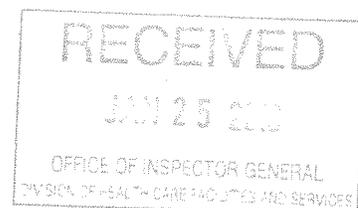
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F 371	<p>Continued From page 31</p> <p>sanitize hands before and after providing resident care.</p> <p>Observation of the lunch meal, on 11/18/12 at 11:00 AM, revealed Certified Nurse Aide (CNA) #1 applied clothing protectors to residents prior to the meal service. CNA #1 was observed to go from resident to resident patting them on the back, touching their hair and hands then placing the clothing protectors around their necks. CNA #9 was observed taking clean damp cloths out of a container and washing residents' hands and mouths then returning the cloth to another container. She would then repeat the process with another resident. She did not sanitize her hands between residents.</p> <p>Observation of CNA #10 during lunch in the dining room, on 11/19/12 at 11:25 AM, revealed she used a bucket of sanitizer on a table and took out a wet cloth and wiped her hands then sat down to feed a resident.</p> <p>Interview with CNAs #1 and #9, on 11/18/12 at 11:25 AM, revealed they should have sanitized their hands between residents to prevent the spread of germs. They stated they had received training on hand hygiene in the past.</p> <p>Interview with CNA #10, on 11/19/12 at 11:50 AM, revealed the bucket had sanitizing solution in it and she thought it was acceptable to use the cloth in the solution to wash her hands. She stated she had seen dietary staff use the solution. She stated she had been trained to sanitize her hands with soap and water or hand sanitizing gel to prevent the spread of infection.</p>	F 371	<p>hand washing. By 12/27/2012 staff in all departments will be inserviced by either the Director of Nursing, Educational Director, or Housekeeping Supervisor on the appropriate techniques of washing hands and the appropriate times to wash hands. On 12/27/2012 staff in all departments was inserviced by either the Director of Nursing, Educational Director, or Housekeeping Supervisor to never use the red sanitizer buckets in dietary for the purpose of hand washing.</p> <p>4. Daily the restorative nurse will observe the breakfast meal and lunch meal in the dining room to ensure staff practices proper hand washing/sanitizing techniques. For the dinner meal the second shift supervisor will observe staff in the dining room to ensure staff practice proper hand washing/sanitizing techniques. On the</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

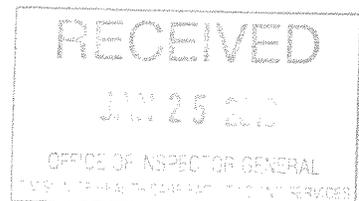
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F 371	Continued From page 32 Interview on 11/20/12 at 8:55 AM, with the Assistant Director of Dietary revealed there were two (2) red buckets in the dining room on 11/19/12 from which one was used to wash tables and the other the dietary staff had used to wash their hands during meal service. Both of the buckets contained a liquid sanitizer. When asked, why the staff did not use the alcohol based sanitizer, she responded it was a chemical. We are to wash our hands in the kitchen. In addition, she also stated using a bucket with a liquid sanitizer was not their normal practice and the dietary staff should have washed their hands. Interview with Licensed Practical Nurse (LPN) #7, on 11/19/12 at 3:00 PM, revealed staff were required to sanitize their hands between residents when providing care to stop the spread of infection. She stated all staff were trained on this procedure. She stated staff were not trained to use the dietary sanitizing solution as a substitute. Interview with the Infection Control Nurse, on 11/20/12 at 1:35 PM, revealed all employees received training on hand hygiene when hired and annually.	F 371	weekends the Week-end Nurse Supervisor will monitor staff for all three meals in the dining room to ensure staff practice proper hand washing/sanitizing techniques. The nurse supervisor monitoring the meal will address any staff member found to not practice proper hand washing/sanitizing techniques immediately. Staff will be instructed by the nurse supervisor to practice proper hand washing/sanitizing. The Restorative Nurse, Second Shift Supervisor and Week-end Supervisor will record on a Staff Education log when they have to instruct staff to practice proper hand washing/sanitizing techniques. The log will be given to the Educational		
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	F 441			

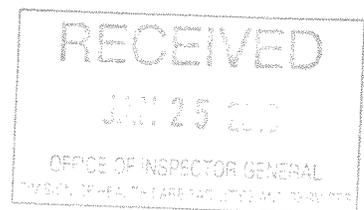


Director weekly to ensure staffs understanding and consistently practicing good hand washing/sanitizing techniques. Monthly the Educational Director will provide the Quality Assurance Committee with a report of the Employee Hand Washing/Sanitizing Technique Education opportunities. If the Quality Assurance Committee finds more than 10 episodes of Nurse Supervisors providing individual education in the dining room related to hand washing/sanitizing the recommendation will be made to in-service all staff again on the proper hand washing/sanitizing techniques.

The Dietary Manager will monitor the dietary staff daily to ensure dietary employees practice proper hand washing techniques. Any dietary staff member found not practicing proper hand washing techniques will be immediately advised by the Dietary Manager on proper hand washing. On weekends the Weekend supervisor will monitor the dietary staff to ensure dietary employees practice proper hand washing techniques. Any dietary staff member found not practicing proper hand washing techniques will be immediately advised by the



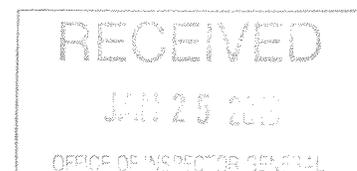
Supervisor on proper hand washing techniques. The Dietary Manager and Week-end Supervisor will keep a Staff Education log to document when a dietary employee had to be advised to practice proper hand washing technique. Weekly the dietary department will supply the Educational Director with their Staff Education log. Monthly the Education Director will provide the Quality Assurance Committee with a report summarizing the educational opportunities for the dietary department related to proper hand washing practice. If the Quality Assurance Committee finds more than 10 episodes of Dietary Supervisors providing individual education to dietary staff related to hand washing techniques the recommendation would be made to in-service dietary staff again on proper hand washing techniques.



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 33</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</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, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an infection control plan to prevent the spread of disease as evidenced by failure to follow isolation/contact precautions for two (2) of</p>	F 441	<p>Completion Date: 12/28/2012</p> <p>F 441</p> <p>1. On 11/19/2012 LPN #8 that had cared for Resident #7 was instructed by the Unit B Coordinator the importance of donning a PPE gown prior to entering the resident's room, and the importance of cleaning the glucose monitoring machine with dispatch cleaner after each use with a resident.</p> <p>2. On 11/20/2012 the Unit Coordinator for Unit A and the Unit Coordinator for Unit B ensured residents with a Physician order for isolation had the proper signage outside their room, and that staff understood what the sign meant. The Unit Coordinators also ensured that there were proper PPE available for staff to utilize prior to entering an isolation room.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

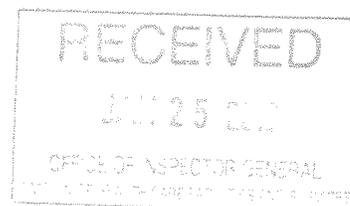
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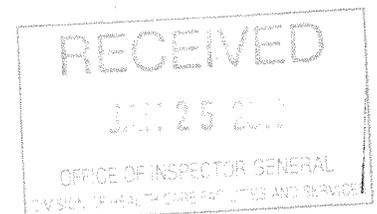
F 441	<p>Continued From page 34</p> <p>nineteen (19) sampled residents and one (1) unsampled resident (Residents #7 and #8); for failure to ensure staff sanitized hands between residents when providing care; and for failure to ensure clean clothing was covered during transport. Additionally, the facility failed to ensure the medication carts remained clean and protected from contamination. The facility failed to ensure blood glucose monitoring machines coming from Isolation/contact precautions rooms were sanitized prior to placing them back on the medication cart.</p> <p>The findings include:</p> <p>Review of the facility's policy for Handwashing, undated, revealed staff should wash their hands before and after providing resident care.</p> <p>Review of the facility's policy for Infection Control, undated, revealed staff should wash their hands frequently with soap and water while providing care for residents with Clostridium Difficile. In addition, the facility policy for Methicillin Resistant Staphylococcus Aereus (MRSA) care revealed staff should wash their hands after removing gloves.</p> <p>1. Observation of the lunch meal, on 11/18/12 at 11:00 AM, revealed Certified Nurse Aides (CNA) #1 and #9 preparing residents for the meal. CNA #1 was observed placing clothing protectors on residents and patting them on the arms and backs and adjusting wheelchairs. She did not sanitize her hands between residents. CNA #9 was observed removing wet cloths from a container and washing residents hands and</p>	F 441	<p>3. On 11/21/2012 the policy for Clostridium Difficile was reviewed and updated by the Administrator and Vice President of Operations. On 12/04/2012 the Administrator, Director of Nursing and Infection Control Nurse reviewed and updated the facility policy on Isolation. On 12/04/2012 the Administrator, Director of Nursing, and Infection Control Nurse reviewed and update the facilities policy on Infection Control. By 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the proper way to document an isolation, when and who to place in isolation, and how to enter and exit an isolation resident room. On 12/27/2012 staff in all departments will be inserviced by one of the following people the Staff</p>	
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F 441	<p>Continued From page 35</p> <p>faces, then placing the soiled cloth in a container. She was observed not sanitizing her hands between residents.</p> <p>Interview with CNAs #1 and #9, on 11/19/12 at 11:45 AM, revealed they should have sanitized their hands to prevent the spread of infection.</p> <p>Observation of the lunch meal, on 11/19/12 at 11:45 AM, revealed dietary staff had a bucket of sanitizing solution on a counter in the dining room. CNA #10 was observed to dip her hands into the solution between residents.</p> <p>Interview with CNA #10, on 11/19/12 at 12:00 PM, revealed she should have used the provided hand sanitizer to sanitize her hands. She stated she did not know what was in the bucket but had observed dietary use the solution to wipe off tables when soiled. She stated she should have used the provided hand sanitizer between residents to prevent the spread of germs.</p> <p>Interview with the Infection Control Nurse, on 11/20/12 at 1:30 PM, revealed she was responsible for the infection control program in the facility. She stated she made random observations of staff and compliance with the infection control policies. She indicated nursing staff were required to wash their hands prior to and after providing resident care to prevent the spread of infection.</p> <p>2. Observation of Resident #7, on 11/19/12 at 10:45 AM, revealed Licensed Practical Nurse (LPN) #8 in the resident's room, finishing a check of the resident's blood sugar. She did not have a PPE gown on.</p>	F 441	<p>Development Coordinator, Director of Nursing, Dietary Director, or Housekeeping Supervisor on the facilities Infection Control Policy.</p> <p>On 11/28/2012 the facility policy for transporting residents clothing was developed by the Administrator and the Housekeeping Supervisor. On 11/28/2012 the Housekeeping Supervisor was inserviced by the Administrator on the importance of coving clean lining while it is being transported through the facility. On 12/14/2012 the Housekeeping Supervisor inserviced the Housekeeping and Laundry employees regarding the facilities policy on transporting residents clothing through the facility and the importance of keeping the clean laundry covered during transport.</p>		



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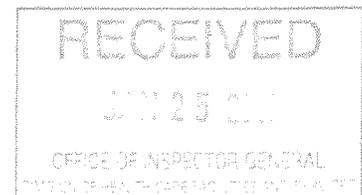
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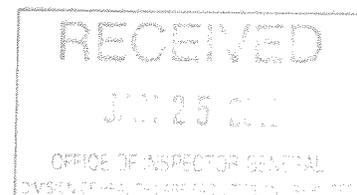
F 441	<p>Continued From page 36</p> <p>Interview with LPN #8, on 11/19/12 at 10:45 AM, revealed she was not aware she was to don a gown prior to entering a room with contact precautions. She had seen the signage notifying staff that the residents were on contact precautions and agreed the sign informed staff to gown prior to entering the room. She stated her actions could spread infection to other residents.</p> <p>Interview with the Infection Control Nurse, on 11/20/12 at 1:30 PM, revealed nursing staff were to follow the instructions of the signage for contact precautions.</p> <p>3. The facility did not provide a policy on the transport of linen/laundry.</p> <p>Observation, on 11/19/12 at 9:00 AM, revealed the Laundry Manager was pushing a metal laundry basket on wheels with a bar attached over the basket to hang clothes, with laundry in the basket and clothes hanging on the bar, uncovered, down the 400 Hall toward the nursing station. After passing the nursing station, the basket continued to be pushed down the 500 Hall.</p> <p>Interview, on 11/20/12 at 1:05 PM, with the Laundry Manager revealed there was no policy, to her knowledge, for the transport of linen/laundry. She also revealed laundry was to be covered during transport for sanitation and infection control purposes. She revealed when the linen/laundry was covered, it was protected from anything that might come in contact with the linen/laundry. She stated she had been</p>	F 441	<p>4. When there is a resident in isolation the Educational Director will observe staff on each shift entering the resident room, during care and when leaving the residents room. If the Educational Director notes a breach in the infection control policy she will stop the staff member immediately, address the issue and assist the staff with proper infection control practice. Weekly the Educational Director will supply the Director of Nursing with a report noting any noted issues with staff properly following isolation/infection control policies. The report from the Educational Director will include the actions he/she took to educate and correct the noted issue. Monthly the Educational Director will supply the Quality Assurance Committee with a report of her observations, interventions and educations of staff related to</p>	
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F 441	<p>Continued From page 37 in-serviced on the transport of linen/laundry.</p> <p>Interview, on 11/20/12 at 2:15 PM, with the Infection Control Nurse revealed that she had nothing to do with the linen/laundry as it related to infection control.</p> <p>4. Review, of the facility's handwashing policy (undated), revealed the final step in the handwashing process should include turning the water off with a towel so as not to contaminate the hands.</p> <p>Observation, on 11/19/12 at 10:30AM, revealed CNA #1 did not wash her hands upon entering the resident's room and prior to donning gloves to assist the nurse who was performing the skin assessment for Resident #2. In addition, CNA #1 was observed washing her hands during and after care of Resident #1, but did not use a paper towel to turn off the faucet handles after washing her hands.</p> <p>Interview, on 11/20/12 at 8:30 AM, with CNA #1 revealed hands should be sanitized or washed prior to performing resident care. Handwashing should include turning off the faucets with a paper towel once hands were washed. Failure to do so could cause recontamination of clean hands, and the spread of infection to Resident #2 and to other residents and staff in the facility.</p> <p>Interview, on 11/20/12 at 10:40 AM, with the Assistant Director of Nursing (ADON), revealed hands should be washed/sanitized before giving resident care, even if gloves were worn, and that a paper towel should be used to turn off faucets after hands were washed.</p>	F 441	<p>residents who are in isolation and over all infection control. The Quality Assurance Committee will review the reports for compliance with facility policies on isolation and infection control.</p> <p>Weekly the administrator will randomly observe the Housekeeping Employees to ensure clean linens and resident clothing are being covered during transportation through the facility. If laundry is found to be transported in violation of the facility policy employees will be address immediately to remedy the issue. Monthly the Administrator will provide a report to the Quality Assurance Committee regarding the proper or improper transportation of clean laundry through the facility.</p>		



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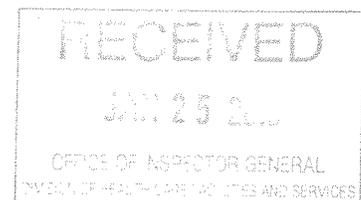
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2012
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F 441	<p>Continued From page 38</p> <p>The ADON stated hand hygiene instruction occurred upon hire, and at all-staff meetings which usually occurred on the third Friday of each month. The ADON stated she performed periodic spot checks for proper hand hygiene technique among her staff, and staff members were provided with inservice instruction as needed. The potential problem with not consistently following all steps in the hand washing process would be the spread of infection to the resident receiving care, other residents or staff in the facility.</p> <p>Interview, on 11/20/12 at 2:15 PM, with the Infection Control Nurse revealed she expected direct care staff to consistently observe proper hand hygiene and glove changes, which included washing hands before and after giving resident care, and prior to donning gloves and upon removal of gloves. In addition, a paper towel should be used to turn off faucets after hands have been washed.</p> <p>5. Review of the facility's policy regarding blood glucose monitoring machines(accuchecks), dated 02/17/11, revealed accuchecks were to be sanitized using Dispatch cleaner after use on a resident. The policy did not address sanitizing of accuchecks after use in isolation.</p> <p>Observation of Resident #7 on contact precautions/isolation, on 11/19/12 at 10:45 AM, revealed Licensed Practical Nurse (LPN) #8 in the resident's room, finishing a check of the resident's blood sugar. She was ungowned and holding the blood sugar monitoring machine</p>	F 441		
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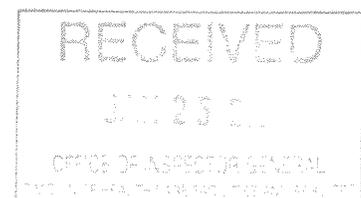
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F 441	Continued From page 39 which she proceeded to place on top of the medication cart when she left the room.	F 441	Completion Date: December 28, 2012	
F 465 SS=E	<p>Interview with LPN #8, on 11/19/12 at 10:45 AM, revealed she was not aware the blood sugar machine needed to be cleaned prior to placing it back on the clean medication cart top. She had seen the signage notifying staff that the residents were on contact precautions She stated her actions could spread infection to other residents.</p> <p>Interview with the Infection Control Nurse, on 11/20/12 at 1:30 PM, revealed blood sugar machines should be sanitized after being used in isolation/contact precautions rooms prior to placing them back on the medication cart.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to ensure hot water temperatures in resident rooms were, at least, one hundred (100) degrees Fahrenheit for five (5) of five (5) rooms observed. Hot water temperatures ranged from seventy-six (76) to ninety-six (96) degrees.</p> <p>The findings include: Review of the facility policy, Water Temperature</p>	F 465	<p>F 465</p> <p>1. Resident #7s water was tested on 11/21/2012 by the Maintenance Director to ensure proper water temperature was achieved and maintained between 100 and 110 degrees. Water temperatures in rooms 104, 108, 103, 110, and 301 were tested on 11/21/2012 by the Maintenance Director to ensure proper water temperatures was achieved and maintained between 100 and 110 degrees. Room 104 had the clogged pipe cleaned and the leak repaired on 12/06/2012 by the Maintenance Director. On 12/13/2012 the Maintenance Director reinstalled circulator lines from the circulator pump to the water heater to increase warm water flow to the mixing valves. This is anticipated to increase the amount of hot water flowing through the water lines to the resident's rooms.</p>	



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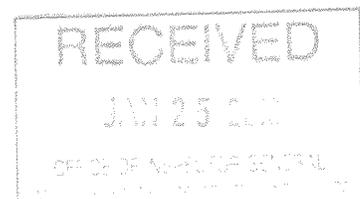
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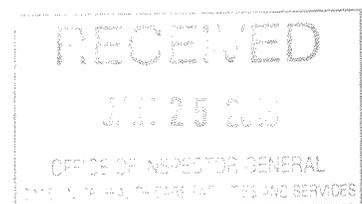
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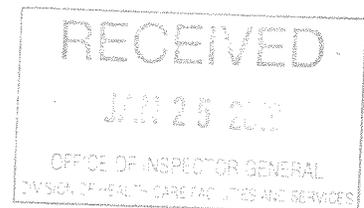
F 465	<p>Continued From page 40</p> <p>Test, undated, revealed resident area hot water temperatures would be at 100 to 110 degrees. Maintenance will use a rotating schedule to check water temperatures. Utilizing the water temperature log would ensure a resident's room on each six halls would be tested daily.</p> <p>Observation of resident rooms, on 11/18/12 at 9:10 AM, revealed water temperatures in resident areas were not, at least, 100 degrees. Room 104's water was at 84 degrees. Room 108's water was at 84 degrees. Room 103's water was at 96 degrees. Room 301's water was at 78 degrees. Room 110's water was at 99 degrees. In addition, the sink in Room 104 was clogged and the pipes were leaking water into a bucket under the sink.</p> <p>Interview with Maintenance, on 11/18/12 at 9:30 AM, revealed the water temperatures were routinely measured to ensure water in resident rooms was between 100 and 110 degrees. He stated he would adjust the water temperatures because the water was too cool.</p> <p>Interview with Resident #7, on 11/19/12 at 2:00 PM, revealed the water in the sink in the room was cool in the mornings and a little warmer later in the afternoon.</p>	F 465	<p>2. All resident in the facility have the potential to be effected by this deficient practice, but no others water temperatures were found to be out of compliance. The Maintenance Director and Maintenance Assistant conducted water temperature test of facility sinks and showers on 11/22/2012.</p> <p>3. On 12/11/2012 the Administrator and Maintenance Director reviewed the facility water temperature policy. On 12/11/2012 the Maintenance Director and Maintenance Assistant were inserviced by the Administrator on the importance of recording accurate first readings of a water temperatures. If improper water temperatures are found in a resident room Maintenance will adjust water temperatures at the mixing valve to achieve proper water temperature of 100 to</p>	
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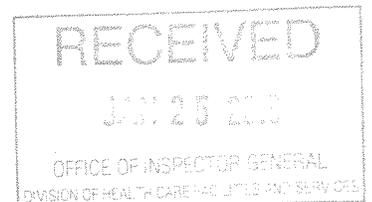
110 degrees*at the point of delivery for the resident. On 12/13/2012 the Maintenance Director reinstalled circulator lines from the circulator pump to the water heater to increase warm water flow to the mixing valves. This is anticipated to increase the amount of hot water flowing through the water lines to the resident's rooms. On 12/14/2012 the Maintenance Director took water temperatures on the 100 hall where water temperatures were found to be an issue. Water temperatures were accurate and within 100 to 110 degrees compliance.



4. On 12/10/2012 the schedule for the "Water Temperature Log" was reviewed by the Administrator and Maintenance Director. The Water Temperature Log is used to determine when and where water temperatures will be taken in resident rooms and unit shower rooms. Monday thru Friday the Maintenance Director or Maintenance Director Assistant will take water temperatures in resident rooms and unit shower rooms. A room for each hall is check daily (Monday thru Friday), and by the end of a two week period every resident room water temperature in the facility has been tested. During a two week period the water in the unit A and B shower rooms will have been tested six times each. If there is an issue established with water temperatures during these test the water temperature will be adjusted at the designated halls mixing valve, and the water temperature will be retested to ensure the appropriate water temperature (100 to 110 degrees) has been achieved. If the Maintenance Director or Maintenance Director Assistant find temperatures over 110 degrees or under 100 degrees they will inform the Administrator immediately. Monthly the



Maintenance Director will provide the quality assurance team a report of water temperatures, any issues, and solutions to those issues. Monthly during resident council, residents will be asked if the temperature of their water is satisfactory. Any issues voiced by the resident council will be forwarded on to the Maintenance Director and Administrator. The Maintenance Director will respond to the issues, address the issue, follow up with the residents, and Activity Director. The Activity Director will present any resident council voiced issues regarding water temperatures, and Maintenance response to the Quality Assurance team monthly. The Quality Assurance Team will review the audits from Maintenance and voiced resident issues to ensure that compliance is being achieved. The Quality Assurance Team will know the plan is effective because there will be no resident injury received from hot or cold water use.



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

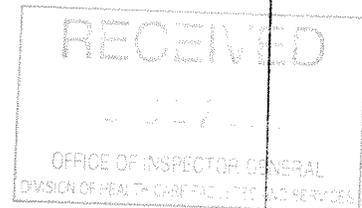
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1997, 2000</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 11/20/12. The Richwood was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty (120) beds with a census of ninety three (93) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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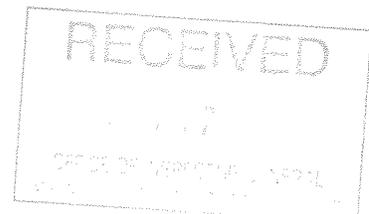
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Elisea [Signature]* TITLE: *X Administrator* (X6) DATE: *12/14/12*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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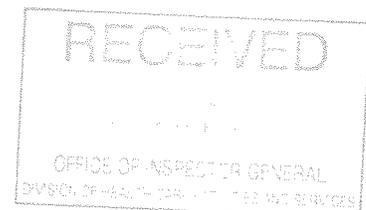
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K 000	Continued From page 1	K 000	Completion Date: 12/28/2012	
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds, with a census of ninety three (93) on the day of the survey. The facility failed to ensure penetrations in the smoke partition were sealed with a material capable of maintaining the smoke resistance of the smoke barrier. The facility failed to ensure the staff was knowledgeable of the requirement for sealing penetrations of a smoke barrier.</p>	K 025	<p>K 025</p> <p>1. The unsealed area around the sprinkler pipe located in the ceiling above the 200 hall was filled in with fire caulk on 11/20/2012 by the maintenance director. The three (3) by three (3) inch hole cut into the drywall in the above the ceiling of the 200 hall was repaired and sealed with fire caulk on 11/20/2012 by the maintenance director.</p> <p>2. All other areas above the ceiling in the facility were evaluated by the Maintenance director on 11/21/2012 to ensure there were no other breaches in the smoke barriers.</p> <p>3. On 11/21/2012 the Maintenance Director was inserviced by the administrator on the importance of ensuring that there were not breaches in the smoke barriers. The Maintenance Director was instructed by the Administrator on 11/21/2012 any time an outside contractor is in the building doing work to the physical facility that the</p>	



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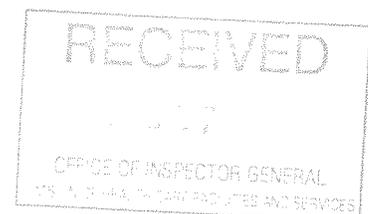
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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 11/20/12 at 8:39 AM, with the Director of Maintenance revealed the smoke partition, extending above the ceiling located in the 200 Hall had an unsealed penetration around a sprinkler pipe and a three (3) inch by three (3) inch hole cut through the drywall and had not been repaired. The penetrations were not filled with a material rated to maintain the smoke resistance rating of the wall.</p> <p>Interview, on 11/20/12 at 8:39 AM, with the Director of Maintenance revealed they were aware of the requirements for sealing penetrations in smoke barriers but not aware of the unsealed penetration or the three (3) by three (3) inch hole in the smoke partition.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised</p>	K 025	<p>Maintenance director will go behind the contractor to ensure that if a breach in a smoke barrier has occurred that it will be repaired with fire rated materials immediately. Monthly the Maintenance Director will visually inspect all smoke barriers to ensure they are intact and that no penetrations are present. On 11/21/2012 the facility policy on Smoke Barriers was reviewed and updated by the Administrator and Maintenance Director.</p> <p>4. Monthly the Maintenance Director will visually inspect all smoke barriers to ensure they are intact and that no penetrations are present. The Maintenance Director will maintain a log of smoke barriers and their integrity. Any issues found with a smoke barrier will be noted on the log. Monthly stating December 12, 2012 the Maintenance Director will submit his smoke barrier log to the Quality Assurance Committee for review.</p>	



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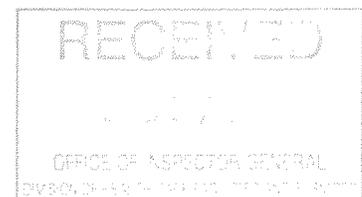
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K 025	Continued From page 3 automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 19.3.7.4 Not less than 30 net ft ² (2.8 net m ²) per patient in a hospital or nursing home, or not less than 15 net ft ² (1.4 net m ²) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier.	K 025		



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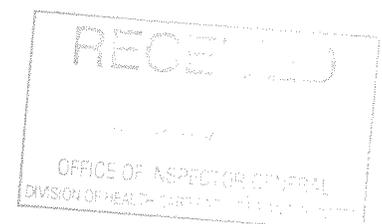
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K 025	Continued From page 4 On stories not housing bed or litterborne patients, not less than 6 net ft ² (0.56 net m ²) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 025	Completion Date: 12/28/2012	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 029	1. On 12/05/2012 self-closing hinges were applied by the Maintenance director to the classroom closet located in the 100 Hall. The Sprinkler Riser Room located in the Kitchen, Mechanical Room located in the Assistant Director of Nursing Office, the Soiled Linen Room located in the 200 Hall, Medical Records Office, and the Trash-Linen Closet located in the 600 Hall all had self-closing devices installed on doors on 12/20/2012 by the Maintenance Director. 2. On 11/27/2012 the Maintenance Director inspected all other doors in the facility that protect hazardous storage areas to ensure that self closing devices where in place and properly functioning. There were two (2) other doors found without self-closing devices. Self-closing devices were placed on the two (2) identified doors on 12/20/2012 by the Maintenance Director.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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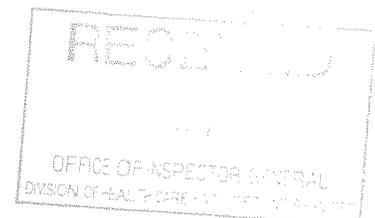
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
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K 029	<p>Continued From page 5</p> <p>determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of ninety three (93) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The facility failed to ensure the staff was knowledgeable of the requirement for self closing devices in hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 11/20/12 between 8:00 AM and 2:30 PM, with the Director of Maintenance revealed the following doors did not have a self-closing device installed and the doors were protecting hazardous storage areas. The locations are as follows:</p> <ol style="list-style-type: none"> 1) Classroom closet located in the 100 Hall. 2) Sprinkler Riser Room located in the Kitchen. 3) Mechanical Room located in the Assistant Director of Nursing Office. 4) Soiled Linen Room located in the 200 Hall. 5) Medical Records Office. 6) Trash-Linen Closet located in the 600 Hall. <p>Interview, on 11/20/12 between 8:00 AM and 2:30 PM, with the Director of Maintenance revealed they were not aware the doors to these rooms were required to be self-closing.</p>	K 029	<p>3. On 11/26/2012 the Maintenance Director was inserviced by the Administrator regarding the importance of having self-closing devices in hazardous areas. Such areas are areas that store materials that are considered combustible e.g., combustible in quantities considered hazardous, boiler and fuel-fired heater rooms, Central/bulk laundries larger than 100 ft, paint shops, repair shops, soiled linen rooms, trash collection rooms. Also on 11/26/2012 the Administrator ensured that the Maintenance utilizes the Life Safety Code Guidance for Certified Long Term Care Facilities manual that was intended to provide guidance and helpful information for navigating through the NFPA 101, Life Safety Code certification survey.</p> <p>4. Monthly starting in December of 2012 the Maintenance Director will check all doors that store materials that are considered combustible to ensure the self-closing devices are working properly. All door with self-closing devices will be put on a</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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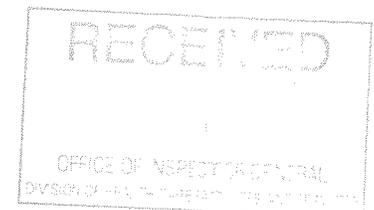
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K 029	Continued From page 6 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops	K 029	log sheet with the location of the door. This log sheet will be used by the Maintenance Director to ensure all doors are checked, and if problems are noticed the issue will be documented and repaired. The date that the issue with the self-closing door was detected will be noted along with the date the issue was resolved. Monthly the Self-Closing Door Device log will be submitted to the Quality Assurance meeting for review. Also monthly the Maintenance Director will inform the Administrator during morning meeting if any issues are noted with a self-closing device. The Administrator will follow up with the Maintenance Director the next day to ensure the issue is resolved.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	Continued From page 7 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	Completion Date: 12/28/2012	
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments,	K 050	K 050 1. In the future fire drill will be held at random times. 2. All residents have the potential to be effected by this deficient practice. 3. On 11/26/2012 the Administrator inserviced the Maintenance Director and Maintenance Assistant on the importance of doing fire drills at random times. A schedule was developed on 12/10/2012 by the Administrator and Maintenance Director of when the fire drills will occur throughout the year to ensure the drills are conducted quarterly on each shift and at unexpected times under varied conditions on all shift. The Maintenance Director will utilize a Fire Drill Report to record the events of each fire drill conducted in the facility. The Maintenance Director was inserviced on 12/10/2012 by the Administrator on how to utilize the Fire Drill Report form.	



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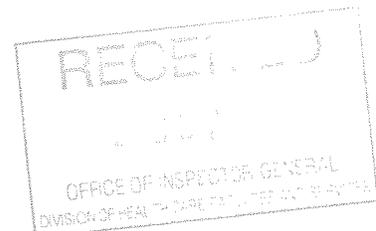
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K 050	Continued From page 8 one hundred twenty (120) residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times. The facility failed to ensure the staff was knowledgeable of the requirement for fire drills. The findings include: Fire Drill review, on 11/20/12 at 9:59 AM, with the Director of Maintenance revealed the facility failed to conduct fire drills at unexpected times on all shifts. Interview, on 11/20/12 at 9:59 AM, with the Director of Maintenance revealed they were not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	4. Monthly the Maintenance Director will inform the Administrator that the fire drill will occur by utilizing the set fire drill schedule. The Administrator will assure that the fire drill did occur at the designated date, time and shift. Both the Administrator and Maintenance Director will sign and date the Fire Drill Report to indicate that the drill occurred as scheduled. The Fire Drill Report will be presented to the Quality Assurance Committee monthly by the Maintenance Director for review of fire drills being carried out quarterly, on each shift and at unexpected times. Any issues noted with the timing of the fire drill will be addressed by the Quality Assurance Committee.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056	Completion Date: 12/28/2012 K 056 1. No specific residents were identified as being affected by the deficient practice.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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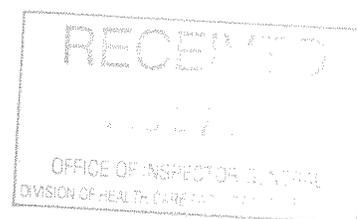
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K 056	Continued From page 9 supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure sprinkler heads were not blocked by light fixtures on the ceiling, and the facility had complete sprinkler coverage. The facility failed to ensure the staff was knowledgeable of the requirement for sprinkler coverage. The findings include: Observations, on 11/20/12 between 8:00 AM and 2:30 PM with the Director of Maintenance revealed the sprinkler heads located in the Kitchen, Dry Storage Room, and the Clean Utility Room at A Nurses Station were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed an alcove located in the 100, 300, 400, and 500 Halls did not have sprinkler coverage. The alcoves had a lower ceiling height than the corridor and were used for	K 056	2. All residents of the facility have the potential to be affected by this deficient practice. 3. On 12/4/2012 the Maintenance Director was inserviced by the administrator on the NFPA 13 Standards regarding the location and spacing of ceiling sprinkler heads. Sprinkler heads shall be positioned in accordance with the minimum distances so that they are located sufficiently away from obstructions such as truss webs and chords, pipes columns, and fixtures. The Maintenance Director was instructed by the Administrator on 12/4/2012 to utilize the <u>Life Safety Code Guidance for Certified Long Care Facilities</u> manual to be aware of regulations related to proper sprinkler head placement and coverage. On 12/12/2012 the	



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K 056	Continued From page 10 non-combustible storage. Interview, on 11/20/12 between 8:00 AM and 2:30 PM with the Director of Maintenance revealed they were unaware sprinkler heads could have no obstructions below the deflector within 12 inches of the head. Further interview revealed they were not aware the building did not have complete sprinkler coverage. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to	K 056	Maintenances Director received a quote from Brown Sprinkler Company on the replacement of the inappropriate placed sprinkler heads in the Kitchen dry storage room and the clean utility room at A Nurses Station. The quote also included placing needed sprinkler coverage for the alcoves located in the 100, 300, 400 and 500 halls. The Brown Sprinkler Company has been scheduled on 12/18/2012 to start work on the designated sprinkler issues with work completed by 12/27/2012. 4. Monthly the Maintenance Director will audit different area of the facility to identify any sprinkler heads that could be considered obstructed. After completing the monthly audit of sprinkler of the Maintenance Director will report the Administrator any	



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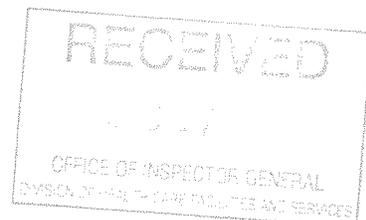
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K 056	<p>Continued From page 11 provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector of Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>21/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>31/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>51/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>71/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>91/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>161/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector of Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 056	<p>findings of structurally obstructed sprinklers. The Administrator will contact Brown Sprinkler Company the same day to schedule replacement of identified obstructed sprinklers. Monthly the Administrator will report to the Quality Assurance Committee any sprinklers heads that were found to be inappropriate placed, scheduled date of repair and the actual completion date of the sprinkler installation/replacement.</p>	
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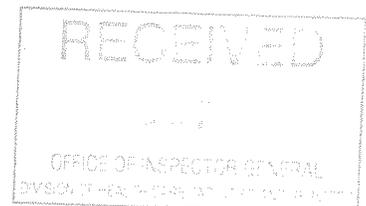
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K 056	Continued From page 12	K 056	Completion Date: 12/28/2012	
K 062 SS=F	<p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure the staff was knowledgeable of the requirement for sprinkler heads and testing of gauges on sprinkler risers.</p> <p>The findings Include:</p> <p>Observation, on 11/20/12 between 8:00 AM and 2:30 PM, with the Director of Maintenance revealed insulation blocking the sprinkler heads located in the attic of the 100, 200, 300, and 400 Hall. The insulation was the blow in type that had blown around during high wind conditions and attached itself to the sprinkler heads.</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. No specific residents were identified as being effected by this deficient practice. 2. All residents in the facility have the potential to be effected by this deficient 3. On 11/20/2012 the Maintenance Director removed the insulation from the sprinkler heads located in the attic of the 100, 200, 300 and 400 halls. On 11/21/2012 the Maintenance Director was inserviced by the Administrator regarding the importance of doing monthly visual checks of the sprinkler heads that are located in the facilities attic areas. On 12/12/2012 the Maintenance Director received a proposal from Brown Sprinkler Company to have the sprinkler gauges replaced. The sprinkler gauges are scheduled to be replaced on 12/18/2012 by Brown Sprinkler Company. 	



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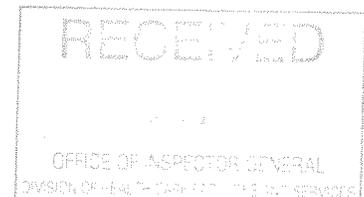
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 13</p> <p>Interview, on 11/20/12 between 8:00 AM and 2:30 PM, with the Director of Maintenance revealed the facility had just had a couple of high wind days and that's when the insulation must have blown on the sprinkler heads. Further interview revealed he was not aware the insulation would blow like that and had never noticed it before during his inspections of the attic.</p> <p>Sprinkler testing record review, on 11/20/12 at 10:12 AM, with the Director of Maintenance revealed the facility did not have documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last five (5) years.</p> <p>Interview, on 11/20/12 at 10:12 AM, with the Director of Maintenance revealed he was not aware the sprinkler gauges needed to be replace or calibrated every five (5) years.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p>	K 062	<p>4. When the Maintenance Director conducts the monthly visual inspection of the facility attic sprinkler heads he/she will record their findings on the Sprinkler Head Log. The log lists all facility areas that have sprinkler heads and if issues are noticed there is an area to document the issue. Once the issue is identified the Maintenance Director will address the issue and then document on the Sprinkler Head Log how the issue was resolved. Monthly the Maintenance Director will report the findings of his/her Sprinkler Head inspections to the Quality Assurance Committee and the Safety committee a subcommittee of the Quality Assurance Committee.</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	Continued From page 14 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	The Maintenance Director placed a notification at the sprinkler gauges indicating when the next 5-year inspection will be due. The need to have the sprinkler gauges inspected in 5-years will also be documented in the facility Sprinkler testing record. The Administrator will ask the Maintenance Director annually on or around October 1 st if this is the appropriate year to have the sprinkler gauges inspected. Annually during the second quarter Quality Assurance Committee meeting the Maintenance Director will report if this is the appropriate year to have the sprinkler gauges calibrated or replaced.	



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K 062	<p>Continued From page 15 Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p>	K 062		

