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

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185067		02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR	80 PHILLIPS LANE HODGENVILLE, KY 42748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health survey was initiated on 02/14/12 and concluded on 02/16/12 and the Life Safety Code survey was conducted on 02/14/12 with deficiencies cited at the highest scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be imposed. An abbreviated survey was initiated on 02/14/12 and concluded on 02/16/12 to investigate KY17840. The Division of Health Care substantiated the allegation and deficiencies were cited related to the allegation.	F 000	Sunrise Manor does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed 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.	F 280	F 280 483.20.10(k)(2) Right to Participate Planning Care – Revise CP	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x S Hamilton | TITLE: x NHA | (X6) DATE: x 3/15/12

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 02/16/2012
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748	

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F 280	Continued From page 1	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility failed to revise the comprehensive care plan for one (1) of twenty-two sampled residents. (Resident #3) An indwelling catheter was placed to help promote healing of a pressure sore on Resident #3's coccyx. The care plan was not revised to reflect the change.

The findings include:

The facility utilized the RAI Manual for revision of care plans.

Observation of Resident #3, on 02/14/12 at 12:05 PM, revealed the resident lying in bed with an indwelling catheter inserted with dark yellow urine draining to a bedside drainage bag.

Review of the comprehensive care plan dated 08/17/11, revealed the facility had failed to revise the care plan to address the use of the indwelling catheter. The care plan only addressed bladder incontinence, which the resident no longer had due to the insertion of the indwelling catheter. Review of the clinical record revealed the resident had a hospital stay from February 7-13th, 2012 for an Urinary Tract Infection.

Interview with LPN #2, on 02/16/12 at 2:00 PM, revealed the catheter was placed to help promote healing of a Stage III pressure sore on the resident's coccyx.

Interview with the Assessment Coordinator, on

Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action.

(1) Resident #3 has an updated care plan for the use of the indwelling catheter. The care plan for resident #3 was updated by the Assistant Director of Nursing on 02/16/12. — 2/16/12

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

(1) An audit will be completed by 3-21-12 by the Director of Nursing and Assistant Directors of Nursing on current residents to ensure that the care plans have been updated accordingly and reflect the current physician orders. — 3/21/12

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

(1) The care plans will be brought to the daily clinical meeting Monday through Friday by the MDS nurse or — 3/21/12

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F 280	Continued From page 2 02/16/12 at 3:00 PM, revealed the care plan should have been revised and it was an oversight. The catheter was just missed.	F 280	Assistant Director of Nursing for review to ensure all new physician orders that were written the previous day or any change of condition have been added to the care plan as indicated.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow care plan interventions for two (2) of the twenty-two (22) sampled residents (#1 and #8). Resident #1 had Care Plan interventions relating to the application of Ted Hose between 6 AM-2 PM. Observations, on 02/14/12 and 02/15/12, revealed they were not in place. In addition, staff did not reposition or provide incontinent care every two hours as care planned. Resident #8 had care plan interventions to turn and reposition every two hours; however, this was not observed as completed timely on 2/14/12 and 2/15/12. Refer to F314 The findings include: The facility utilized the RAI Manual in regards to care plans. 1. Observation of Resident #8 during the survey, on 02/14/12 at 2:00 PM, 4:00 PM and 5:00 PM, revealed the resident to be sitting up in the		(2)The Signature Care Consultant reeducated administrative nursing staff including Director of Nursing, Assistant Directors of Nursing, Restorative Coordinator, MDS Coordinators, and Staff Development Coordinator on 2/16/12 on updating care plans for any new physician orders or change of condition as indicated. (3)The Staff Development Coordinator and Director of Nursing will reeducate all active licensed nurses by 3-21-12 on updating care plans for any new physician orders or change of condition as indicated. (4) The Assistant Directors of Nursing will complete audits on 5 residents from each unit weekly for 24 weeks to ensure care plans were updated appropriately for any new physician orders or change of condition.	2/16/12 3/21/12 3/21/12

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F 282	Continued From page 3 wheelchair either at the 1North nurse's station, or in the dining room. Observations, on 02/15/12 at 8:15 AM, 10:30 AM, and 11:30 AM, revealed the resident to be up in the wheelchair out of the room, either at the 1North Nurses station or in the dining room. Review of Resident #8's plan of care revealed interventions for turning and repositioning with every round and as needed. The resident was also assessed on the annual comprehensive assessment dated 03/23/11, to be at risk for pressure sores. Review of the resident s skin assessment sheet, dated 02/09/12, revealed the resident had redness to the left buttocks area; however, it was not opened. A skin assessment observation was completed, on 02/14/12 at 1:45 PM, which revealed an open Stage II area 1cm x 0.6cm with rolling edges. The skin assessment also revealed the resident's brief to be urine soaked. This finding determined that care plan interventions had not been followed. Interview with CNA #1, on 02/15/12 at 3:00 PM, revealed it was sometimes difficult to get the work completed, such as turning and repositioning. Interview with the Director of Nursing, on 02/16/12 at 4:00 PM, revealed there had been concerns on the 1North Unit, and revealed some of the problems had been associated with the previous administrative staff. The DON stated the facility had been trying to work on the problem; however, the facility still had concerns to work out.	F 280	Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. (1) Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated. Include dates when corrective action will be completed. 03/22/12 F 282 483.20 Services by Qualified Persons/Per Care Plan Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. (1) Resident # 8 has an order for Ted hose which is appropriately reflected on the plan of care. Staff caring for resident #8 were reeducated on applying the Ted hose per physician order and plan of care on 2/16/12 by the DON.	3/21/12 3/22/12 2/16/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/16/2012
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F 282	Continued From page 4	F 282	(2) Resident #8 is being turned and repositioned and receiving incontinence care per plan of care. Resident # 8's pressure area under medi boot is healed. Skin assessment is updated. Staff caring for resident #8 were reeducated on turning and repositioning and applying incontinence care per care plan on 2/16/12 by the DON.	2/16/12
	2. Review of Resident #1's clinical record revealed the facility admitted the resident on 4/28/10 with diagnoses of Alzheimer Disease, Dementia, and Immobility. Review of the care plan, dated 8/17/11 and revised on 01/23/12, revealed the facility developed interventions of turning and reposition with instructions to shift the resident's weight to relieve pressure. In addition, staff was instructed to check for incontinence and provide incontinent care. However, there were no specific times or frequency listed. Review of the CNA care plan for February 2012 revealed instructions to check/change the resident every 2 hours and PRN. In addition, bilateral knee high Ted Hose (compression stockings) were to be applied on at 6 AM- 2 PM, then off.		(3) Resident #1 is being turned and repositioned and receiving incontinence care per plan of care. Staff caring for resident # 1, are applying the Ted hose per physician order and plan of care. Staff caring for resident # 1 were reeducated on turning and repositioning and applying incontinence care per care plan on 2/16/12 by the DON.	2/16/12
	On 02/15/12 at 8:00 AM, Resident#1 was observed to be sitting up in a Geri Chair in the main dining room eating breakfast. At 9:10 AM, the resident was observed to be lying in the Geri Chair in the resident's room, asleep. The Geri Chair was reclined. Observation at 10:00 AM revealed the resident remained reclined in the Geri Chair awake. At 11:00 AM, staff pushed the resident in the Geri Chair to the main dining room. Continued observation revealed the resident remained in the dining room until the noon meal was served. The Ted hose were not applied.		(4) Staff are applying barrier cream to the skin of Resident #1 per physician order and plan of care. Skin assessment is updated. Staff caring for resident # 1 were reeducated on applying barrier cream per plan of care by the DON on 2/16/12.	2/16/12
			(5) An Assistant Director of Nursing is in place to supervise the care on the 1 North and 1 South Units as of 2/16/12.	2/16/12

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F 282	Continued From page 5	F 282	Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	
	Interview with LPN #2, on 02/16/12 at 2:00 PM, revealed she thought the Ted Hose had been discontinued. However, review of the most current physician orders revealed the Ted Hose were ordered.		(1) An audit was completed on physician orders of all current residents, by the Director of Nursing and Assistant Directors of Nursing on 3-8-12 to identify all residents with physician orders for Ted hose. The care plans of identified residents with physician orders for Ted Hose were audited and updated as indicated.	3/08/12
	Observation, on 02/16/12 at 2:20 PM, revealed the resident still did not have the Ted Hose on. The nurse later informed the surveyor of a new physician order for the Ted Hose to be applied to the left leg only. (The right foot had a Kerlix bandage covering the pressure sore). Continued Observation at 3:00 PM revealed a Ted Hose compression stocking had been applied to the resident's left leg.		(2) An audit was completed on all current residents by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator and Restorative Coordinator on 3-8-12 to identify residents who require assistance from staff for turning and repositioning as coded on the MDS assessment. The care plans of all current residents requiring assistance from staff for turning and repositioning were audited to ensure the care plan corresponded with the MDS assessment.	3/08/12
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES			
	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents having pressures sores received necessary treatment and services such as turning and repositioning, floating heels, and providing incontinent care, to prevent new			

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F 314	Continued From page 6 pressure sore development for two (2) of the twenty-two (22) sampled residents. (#1 and #8). The findings include: Review of the facility's policy for pressure sore management (revised 12/20/10) revealed to implement a preventive program to prevent additional development of new areas. The presence of one ulcer means the resident is at risk for additional ulcers. Reposition bedfast residents every two hours or more often. Reposition chair-bound residents at least hourly and continue using the steps of the nursing process to promote wound healing. 1. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 06/01/11 with diagnoses of Acute kidney Failure, Alzheimer Disease, Dysphagia, Anemia, and Cerebral Vascular Accident. Review of the resident's annual comprehensive assessment, dated 03/23/11, revealed the resident was assessed to have a severe cognitive impairment and required extensive assist with bathing with one person assist. Review, of the 09/08/11 Quarterly Assessment, revealed the resident required extensive assist of one person with bed mobility, toilet use and was at risk for skin breakdown and was extensive assist of 2 persons for transfer. Review of the last skin assessment, dated 02/09/12, revealed redness to the resident's bottom, with cream continued to be applied as ordered. The current physician's order was to apply Dermorite Barrier Cream as needed. Review of the Care Plan under Activities of Daily	F 320	(3) An audit was completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator and Restorative Coordinator on 3-8-12 to identify all active residents who require assistance from staff for incontinence care as coded on the MDS assessment. The care plans of all current residents that require assistance from staff for incontinence care were audited to ensure the care plan corresponded with the MDS assessment. (4) An audit was completed by the Director of Nursing, Assistant Directors of Nursing, Staff Develop Coordinator, Restorative Coordinator, and Signature Care Consultant on 3-8-12 to ensure that all current residents who are care planned for skin barrier cream have TARs updated as needed to document the application of barrier cream. (5) An Assistant Director of Nursing is in place to supervise the care of residents on unit 1 North and 1 South as of 2/16/12.	3/08/12 03/08/12 02/16/12

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F 314	Continued From page 7 Living (ADL) revealed the resident was to be repositioned while abed every round and as needed. Review of the Pressure Care Plan revealed weekly skin assessments with baths were to be completed, and to check the resident with each round for incontinence and provide pericare with toileting every round. The care plan had an intervention for the resident to be up in the chair twice a day. Observation of Resident #8 during the survey, on 02/14/12 at 2:00 PM, 4:00 PM and 5:00 PM, revealed the resident to be sitting up in a wheelchair either in the open area at the 1 North nurse's station, or in the dining room. Observations, on 02/15/12 at 8:15 AM, 10:30 AM, and 11:30 AM, revealed the resident to be up in the wheelchair out of the room, either in the open area at the 1 North Nurses station or in the dining room. Observation during a skin assessment conducted by LPN #1 for Resident #8, on 02/15/12 at 1:45 PM, revealed the resident's brief was urine soaked. In addition, the observation revealed the resident had an open area to the left buttocks area, which was described by the nurse as a Stage II pressure sore with measurements of 0.1cm x 0.6 cm with the edges rolling. Observation of both heels revealed redness which were blanchable at that time. Interview with LPN #1 during the skin assessment, on 02815812 at 1:45 PM, revealed the resident had orders to turn and reposition every two hours with a skin barrier placed on the resident. There were no protective devices in place. LPN #2, upon entering the resident's room,	F282	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. (1)The Director of Nursing, Assistant Directors of Nursing and Staff Development Coord inator wil l have all active nursing staff reeducated by 3-21-12 on following care plans for the application of Ted hose, turning and repositioning q 2 hours and as needed, incontinence care, and applying skin barrier cream with incontinent episodes. (2)The Director of Nursing, 2nd floor Assistant Director of Nursing and Care Consultant will provide training to new Assistant Director of Nursing for 1 North and 1 South Units by 3-19-12. (3)The Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Restorative Coordinator will complete a weekly audit for 24 weeks on 10% of current residents to ensure turning and repositioning and incontinence care is being provided per plan of care. (4)The Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Restorative Coordinator will complete a weekly audit on 10% of	03/21/12 03/19/12 03/21/12 03/21/12

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F 314	Continued From page 8 stated that area looks like a new one, referring to the area on the buttocks. Interview with CNA #1, on 02/16/12 at 3:00 PM, revealed she was responsible for the care of Resident #8, and revealed she had reported the open area to LPN #2 several days ago. However, review of the CNA Skin Care Alert Sheet, dated 02/14/12, revealed no evidence of any skin problems. Interview with CNA #9, on 02/15/12 at 3:30 PM, revealed these sheets are completed when giving residents a shower, which included observation of the resident's skin. CNA #9 stated these sheets were given to the nurses. If there were skin issues, the sheets are signed, and an assessment of the resident's skin is made. Interview with LPN #8, on 02/16/12 at 3:35 PM, revealed no one reported an open area, on 02/14/12, after the resident's shower. Interview with CNA #10, on 02/16/12 at 3:30 PM, revealed a reddened area had been reported the day before the shower on 02/14/12; however, she stated the area was not opened. Interview with the Director of Nursing, on 02/16/12 at 4:00 PM, revealed there had been concerns on the 1 North Unit, and revealed some of the problem had been with the previous administrative staff. The DON stated they had been trying to work on the problem; however, stated the facility still had concerns to work out.	F282	residents for 24 weeks on current residents with physician orders for Ted Hose to ensure Ted Hose are applied and removed as ordered. (5)The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Restorative Coordinator will complete a weekly audit for 24 weeks on 10% of current residents care planned to have skin barrier cream applied, to ensure this is being completed. (6)The Director of Nursing will monitor progress of new Assistant Director of Nursing. A 90 day evaluation will be completed and will address any areas of improvement needed. (7)All active staff that are noted to be out of compliance with the above audits will receive coaching and counseling up to termination per policy from the Assistant Director of Nursing or Director of Nursing as indicated. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained**	03/21/12 03/21/12 03/21/12

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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748	

(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 314	Continued From page 9	F282	(1) Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated.	03/21/12
	2. Review of Resident #1's clinical record revealed the facility admitted the resident on 4/28/10 with diagnoses of Alzheimer Disease, Dementia, Immobility, Glaucoma, and Hypertrophy prostrate without urinary obstruction. The clinical record revealed the resident was not admitted with existing pressure ulcers. Review of the annual Minimum Data Set (MDS) assessment for 01/09/12, revealed the facility assessed the resident with a severe cognition impairment, incontinent of bowel and bladder and required extensive to total assist from staff to complete ADL tasks. The facility assessed the resident to be at risk for skin breakdown related to immobility, incontinence, and impaired cognition. Review of the care plan, dated 08/17/11 and revised on 01/23/12, revealed the facility developed interventions of turning and reposition with instructions to shift resident's weight to relieve pressure. In addition, staff was instructed to check for incontinence and provide incontinent care. However, there were no specific times or frequency listed. Review of the CNA care plan for February 2012 revealed instructions to check/change the resident every 2 hours and PRN. The care plan instructed 2 assist with this task.		Include dates when corrective action will be completed. 03/22/12	03/22/12
	Review of the clinical record revealed Resident #1 developed a stage I to the left heel on 11/26/11. The pressure area opened up on 12/27/11. A treatment was obtained. Interview with LPN #2, on 02/16/12 at 2:00 PM, revealed the pressure sore developed related to the	F314	F 314 483.5 Treatment/SVCS to prevent/heal pressure ulcers	
			Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action.	
			(1)Resident #8 is being repositioned timely and receiving appropriate incontinence care.	02/16/12
			Barrier cream is being applied to resident #8. There are no open areas on Resident #8 as of 3-8-12.	03/08/12
			Staff caring for resident # 8, were reeducated on 2/16/12 by the Director of Nursing on timely incontinence care and applying barrier cream per orders.	02/16/12
			(2)Resident #1 is being turned and repositioned per care plan while up in the geri chair and while lying in	02/16/12

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F 314	Continued From page 10 pressure of wearing of a Medi-boot. On 02/15/12 at 8:00 AM, Resident#1 was observed sitting up in a Geri Chair in the main dining room eating breakfast. At 9:10 AM, the resident was observed to be lying in the Geri Chair in the resident's room, asleep. The Geri Chair was reclined. Observation at 10:00 AM revealed the resident remained reclined in the Geri Chair awake. Attempts to interview the resident was unsuccessful. At 11:00 AM, staff pushed the resident in the Geri Chair to the main dining room. Continued observation revealed the resident remained in the dining room until the noon meal was served. At 1:00 PM the surveyor was in the resident's room interviewing the spouse. The spouse resides in the same room with Resident #1. Facility staff (CNA# 1 and #2) pushed the Geri Chair back into the resident's room. Permission to observe a skin assessment and incontinent care was given by the spouse. The two CNAs (CNA#1 and #2) stated the resident would have to be placed in bed with a mechanical lift that required a two-person assist. Observation revealed the resident was transferred by a mechanical lift (Maxi Move) and two staff from the Geri Chair to the bed. The resident's pants and incontinent brief was removed. Observation revealed the brief was soaked with urine and urine had leaked onto the mechanical lift pad that had been left under the resident. Observation of the resident's back revealed deep imprints from the lift pad and was slightly red. There was a small area with blisters noted. One of the blisters had opened.	F 314	the bed. Resident #1 is receiving appropriate incontinence care. The mechanical lift pad is being removed under the resident when up in the Geri Chair. Resident #1 has no open areas on the back as of 3-8-12. Staff caring for resident # 1, were reeducated by the Director of Nursing on 2/16/12 on turning and repositioning every 2 hours and prn. (3)An Assistant Director of Nursing is in place to supervise the care on the 1 North and 1 South Units as of 2/16/12. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** (1)The Director of Nursing, Assistant Directors of Nursing, Restorative Coordinator, and Charge Nurses completed skin assessments on 2/15/12 and 2/16/12 on all residents who are dependent on staff for turning and repositioning and incontinence care according to their plan of care. No issues were identified.	03/08/12 02/14/12 02/14/12

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F 314	Continued From page 11 Interview with CNA #1, on 02/15/12 at 1:30 PM, revealed the use of the mechanical lift was always a two-person assist. She revealed there were three (3) aides assigned to the unit and many times the staff would have to wait for another person to assist with the mechanical lift before providing care to residents. That left one aide on the floor to answer call lights and do other tasks. She revealed there were times when she would have to wait for someone to help with the mechanical lift and residents were not always provided incontinent care every two hours. In addition, she stated she had not provided incontinent care for Resident #1 prior to lunch. She revealed all three (3) aides are responsible for the residents on the unit. She stated the CNA would document on the nurse aide worksheet when incontinent care had been given. However, review of the form with CNA #1 revealed Resident #1 had only been provided incontinent care two (2) times during the shift (6 AM-2 PM) and this was including the surveyor's observation at 1:15 PM. Interview with the spouse, on 02/15/12 at 1:50 PM, revealed the resident had been up in the Geri Chair since breakfast and the staff had not provided incontinent care in the room. The spouse revealed it was routine for the resident to be up in the Geri Chair from breakfast to after lunch. The spouse indicated the staff left the lift pad under the resident when out of bed. Review of the January weekly skin assessments revealed on January 16th, 23rd, and the 30th, the resident's coccyx area was assessed to be slightly red. On 02/12/12, blisters were noted to	F 314	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, (1)The Director of Nursing and Staff Development Coordinator will have all active nursing staff re-educated by 3-21-12 on turning and repositioning residents, application of skin barrier cream, timely incontinence care, and removal of mechanical lift pads under residents as appropriate. (2)The Director of Nursing and Staff Development Coordinator will have all active nursing staff re-educated by 3-21-12 on identification of new skin issues and reporting of skin issues to the charge nurse for proper follow up. (3)The Director of Nursing and Staff Development coordinator will have all active nursing staff educated on the c.n.a. skin alert sheet by 3-21-12. The c.n.a. skin alert will be completed on all current residents on their shower days and anytime that a change is noted/observed on the residents' skin. The skin care alert sheet will then be given to the residents nurse for follow up and treatment as indicated by the physician.	03/21/12 03/21/12 03/21/12

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F 314	Continued From page 12 the lower back. Interview with CNA# 2, on 02/16/12 at 8:30 AM, revealed residents are provided incontinent care when getting the resident out of the bed. Incontinent care should be provided every two (2) hours; however, it is hard when there are only three (3) aides for the entire unit and you have to wait for someone to help you with the mechanical lift. She indicated there were times when care could not be provided every two hours as scheduled. Refer to F 353 Interview with LPN #2, on 02/16/12 at 2:00 PM, revealed Resident #1's left heel began as soft tissue that opened. She stated the resident was utilizing a protective boot at the time that caused the pressure sore. She indicated the resident was at high risk for skin breakdown. She stated the resident should be turned and reposition every two (2) hours and provided incontinent care too. She revealed there were three (3) CNAs scheduled for the unit and the nurses had to help the CNAs frequently to get the work done.	F 314	(4)The Director of Nursing, 2nd floor Assistant Director of Nursing, and Care Consultant will provide training to new DON for 1 North and 1 South Units by 3-21-12. (5)The Director of Nursing, Assistant Directors of Nursing, Restorative Coordinator, and Staff Development Coordinator will complete a weekly audit for 24 weeks on 10% of current residents to ensure turning and repositioning and incontinence care is being provided per plan of care. (6) The Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Restorative Coordinator will complete a weekly audit for 24 weeks on 10% of current residents care planned to have skin barrier cream applied, to ensure this is being completed. (7)The Director of Nursing or Assistant Directors of Nursing will complete an audit of all c.n.a. skin alert sheets for two days weekly for 24 weeks to ensure completion and that any new areas have been followed up on as indicated. (8) All active staff that are noted to be out of compliance with the above audits will receive coaching and	03/21/12 03/21/12 3/21/12 3/21/12 3/21/12
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident			

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F 353	Continued From page 13 care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's staffing schedule, it was determined the facility failed to provide sufficient staff to meet the residents' needs including turning, reposition, incontinent care, hydration, personal care, and answering call lights promptly for three (3) of twenty-two (22) sampled residents and one (1) of one (1) unsampled resident. Residents #1, #4, and #10 and unsampled Resident A. Multiple complaints were received from residents and families voicing complaints regarding findings of residents being wet, call lights not answered and water pitchers not within reach. Refer to F314 The findings include: Review of the census revealed the facility had one hundred thirty-seven (137) beds and on 02/14/12 the facility census was one hundred ten (110).	F314	counseling up to termination per policy from the Assistant Director of Nursing or Director of Nursing as indicated. (9)The Director of Nursing will monitor the progress of the new Assistant Director of Nursing. A 90 day evaluation will be completed and will address any areas of improvement needed. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained (1)Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated. Include dates when corrective action will be completed. 03/22/12 F 353 483.30 Sufficient 24-HR Nursing Staff Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. (1) Resident #1 is being turned and repositioned per care plan while up in the geri chair and while lying in the bed. Resident #1 is receiving	3/21/12 3/22/12 2/16/12

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F 353	Continued From page 14 Interview during the Group resident council meeting, on 02/14/12 at 3:00 PM, revealed several unsampled residents stated there was not enough staff to care for the residents. The residents stated those residents who had to be transferred by a mechanical lift and two (2) persons had to wait for long periods of time before they are toileted, changed, or put to bed. In addition, the residents stated call lights were not answered promptly. The residents stated staffing was short on evenings and weekends. The Ombudsman was present during the meeting and stated she had received several concerns regarding staffing. 1. Observation of Resident #1, on 02/15/12 at 8:00 AM, revealed the resident sitting up in a Geri Chair in the main dining room eating breakfast. At 9:10 AM, the resident was observed to be lying in the Geri Chair in the resident's room, asleep. The Geri Chair was reclined. Observation at 10:00 AM revealed the resident remained reclined in the Geri Chair awake. Attempts to interview the resident were unsuccessful. At 11:00 AM, staff pushed the resident in the Geri Chair to the main dining room. Continued observation revealed the resident remained in the dining room until the noon meal was served. On 02/15/12 at 1:00 PM, the resident was assisted back to the resident's room. Permission to observe a skin assessment and incontinent care was given by the spouse. Observation of incontinent care provided by CNA #1 and CNA #2 revealed the resident's incontinent brief was soaked with urine and urine had leaked onto the mechanical lift pad that had been left under the resident. Observation of the resident's back	F 353	appropriate incontinence care. The mechanical lift pad is being removed under the resident when up in the Geri Chair. Resident #1 has no open areas on the back as of 3-8-12. Staff caring for resident # 1, were reeducated by the Director of Nursing on 2/16/12 on turning and repositioning every 2 hours and prn. (2)Resident #4 is receiving timely incontinence care every 2 hours and as needed per plan of care. Resident #4 has fluids within reach and will receive assistance with all meals per plan of care. Staff caring for resident #4 were reeducated on toileting every 2 hours and as needed, keeping the bedside table within reach and assisting with meals. (3)Resident #10 is receiving timely personal care. Staff caring for resident #10 were reeducated on providing assistance to resident #10 for personal care needs. (4)An Assistant Director of Nursing is in place to supervise the care on the 1 North and 1 South Units as of 2-16-12.	3/08/12 3/08/12 3/08/12 2/16/12

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F 353	Continued From page 15 revealed deep imprints from the lift pad and was slightly red. There was a small area with blisters noted. One of the blisters had opened. Interview with Certified Nursing Assistant (CNA) #1, on 02/15/12 at 1:30 PM, revealed it was routine for the unit to be staffed with three CNAs. The facility required two staff to use the mechanical lift and that only left one CNA to answer call lights. If another resident needed to be toileted or turned, they would have to wait for the use of the lift. She indicated incontinent care was not always provided every two hours. Interview with the Director of Nursing, on 02/16/12 at 4:00 PM, revealed she had identified 1-North had heavy care residents and had provided more staffing. However, she was not aware there was only one mechanical lift for 02/14/12 and 02/15/12 to be used for fifteen (15) residents and only three (3) nursing assistants. Review of the list of resident who utilized the total body (Maxi) mechanical lift revealed on 1-North fifteen (15) of the 28 residents on the unit had to be transferred by the Maxi lift and two-persons. Compare to 1-South seven (7) of nineteen (19) used the lifts. On 2- North only four (4) of thirty-one (31) residents used the mechanical lifts and 1-South six (6) of thirty-one (31) residents. 2. Interview with one unsampled resident A's family that resided on the 1 North Wing, on 02/16/12 at 1:00 PM, revealed she felt the facility	F 353	<u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u> (1)All current residents interviewable residents and responsible party of all non-interiewable residents will be interviewed by the Administrator, Social Services Director, Director of Nursing, Human Resource Director, Quality of Life Director, Business office assistant, Assistant Directors of Nursing, Admissions Nurse, Staff Coordinator, Restorative Nurse Manager, Central Supply Clerks, Environmental Services Director, Dietary Director, chaplain and medical records director by 3-21-12 to determine if they are satisfied with the care received or if there is anything that was needed that has not been provided. (2)The Administrator, Director of Nursing, and Signature Care Consultant reviewed the staffing pattern on 2-20-12 to ensure that nursing staff were properly distributed based on resident acuity. (3)An audit was completed by the Director of Nursing and Assistant Directors of Nursing on 2-16-12 on all current residents requiring lift transfer.	3/21/12 2/20/12 2/16/12

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	185057		02/16/2012

NAME OF PROVIDER OR SUPPLIER: SUNRISE MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 80 PHILLIPS LANE, HODGENVILLE, KY 42748

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F 353	Continued From page 16 was short staffed. She stated she had came to see the resident over the weekend and found the resident attempting to toilet self. The resident's daughter stated the resident was suppose to turn on the call light when the resident needed to go to the bathroom; however, interview with unsampled resident A revealed when the call light is activated, someone turns it off at the nurses station, and staff don't come. Interview with the Director of Nursing, on 02/16/12 at 4:00 PM, revealed she was unaware there was a problem with the resident or the family. She stated there had been problems with the previous administrative staff were responsible for monitoring this area. In addition, the DON stated there had been lack of communication, and had found in her own monitoring, the call lights had been deactivated at the desk. 3. Review of the clinical record for Resident #4 the facility admitted the resident on 12/01/04 with the following diagnoses: Cerebral Degeneration, Decline in Health Status/Debility, Generalized Muscle Weakness, Osteoporosis and Dementia. Resident #4 was currently on Hospice. Interview, on 02/16/12 at 2:00 PM, with the next of kin, a niece, revealed Resident #4 had days where he/she did not receive care. The niece had spoken to the staff related to the lack of care and the lack of fluids being within reach of her family member without a resolution. The niece also stated the resident required assistance with meals and she was concerned the staff did not set up or help Resident #4 eat. The niece stated she had called the facility and the phone would ring and ring with nobody available to pick up her	F 353	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. (1)The Administrator and Director of Nursing will review the staffing pattern daily Monday through Friday to ensure staff are properly distributed based on resident acuityto meet the care needs of the residents. (2)All active nursing staff will be reeducated by the Director of Nursing, Staff Development Coordinator or Assistant Directors of Nursing on incontinence care, turning and repositioning, hydration, personal care, and answering call lights by 3-21-12. (3)1 Full Body Lift has been added to 1 North. The number of residents to each full body lift will be monitored weekly by the Assistant Director of Nursing and reported to the Director of Nursing weekly. (4)All interviewable residents and responsible parties of non-interviewable residents will be interviewed monthly for 6 months by the Administrator, Social Services Director, Director of Nursing, Human Resource Director, Quality of Life Director, Business office	3/21/12 3/21/12 3/08/12 3/21/12

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NAME OF PROVIDER OR SUPPLIER: SUNRISE MANOR

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F 353	Continued From page 17 call. A concern for lack of staff was voiced. 4. Record review for Resident #10 revealed the facility admitted the resident on 03/13/06 with a re-admission date of 02/07/12. Resident #10 had the following diagnoses: Urinary Tract Infection, Generalized Muscle Weakness, Multiple Sclerosis (MS), Anemia, and a healed Sacrum wound that was surgically closed. The Minimum Data Set (MDS) Resident assessment and Care Screening for a Significant Change dated 12/09/11 revealed a functional status for toilet and bathing required total assist of one to two persons, and Resident #10 was not able to walk. Interview, on 02/15/12 at 9:15 AM, with Resident #10 revealed since being in the new building the staff are running a lot. The Resident stated that the building was so much bigger than the old facility and the staff was not able to take extra time with him/her. Resident #10 revealed that sometimes he/she did not get the help needed and felt the facility needed more staff to assist the residents with personal care. Interview with the Special Project Administrator, on 02/16/12 at 4:30 PM, revealed he was aware of the staffing concerns; however, did not identify the concerns as a staffing issue and had not developed a plan of action.	F 353	assistant, Assistant Directors of Nursing, Admissions Nurse, Staff Coordinator, Restorative Nurse Manager, Central Supply Clerks, Environmental Services Director, Dietary Director, chaplain and medical records director to ensure care needs are being met and they are satisfied with the care they are receiving. Any issues identified will be addressed accordingly by the Administrator, Director of Nursing and Social Services Director. (5)The Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator and Restorative Coordinator will complete a weekly audit on 10% of residents for 24 weeks to ensure turning and repositioning and incontinence care is being provided per the plan of care. (6) The Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator and Restorative Coordinator will complete a weekly audit on 10% of residents to ensure the water pitchers and call lights are within reach and assistance is being provided to those residents requiring assistance that eat in their room for 24 weeks (7)A call light audit will be	3/21/12 3/21/12 3/21/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/16/2012
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748	

(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 431	Continued From page 18 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policies, it was determined the facility failed to store and label medications in accordance with currently accepted professional principles and facility policies. In four (4) of four (4) medication carts on the second floor, nasal sprays were	F363 F431	completed Monday through Friday by Administrator, Director of Nursing or Assistant Director of Nursing to ensure call lights are being answered within a timely manner. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained (1) Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated. Include dates when corrective action will be completed. 3/21/12 F 431 483.60 Drugs and Biologicals Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. (1)Nasal sprays were separated from oral medications, eye drops were separated from nasal sprays and oral medications and the expired tuberculin vial was discarded on 2/15/12 by the ADON.	3/21/12 3/22/12 2/15/12

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F 431	Continued From page 19 found stored together with oral medications. There was no division between the medications. A bottle of eye drops was also found in one of the carts stored with the nasal sprays and oral medications. In addition, one (1) of one (1) medication refrigerators on the second floor had two (2) open undated vials of tuberculin vaccine. The boxes the vials were stored in were dated; however, the dates exceeded the expiration dates of the open vials. The findings include: Review of the facility's policy Medication Administration-Storage of Medication (Effective 12/2010) revealed orally administered medications were kept separate from externally used medications. The policy stated outdated medications were immediately removed from stock. In addition, it stated medication storage conditions were monitored on a routine basis and corrective actions were taken if problems were identified. Review of the facility's policy Medication Administration-Medication Labels (Effective 12/2010) revealed stock medication would include applicable statements. The date opened was not present on two (2) tuberculin vials. Interview, on 02/16/12 at 3:45 PM, with the Director of Nursing (DON) revealed medications were to be stored separately in the medication cart. Eye drops were to be separate from inhalers and oral medication separate from inhalers. Observation, on 02/15/12 at 7:30 AM, of the Two South #1 Medication Cart revealed six (6) nasal	F 431	(2)All medication carts and medication refrigerators were audited on 2/15/12 by the ADON. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** (1)The Director of Nursing, Assistant Directors of Nursing, Restorative Coordinator, and Staff Development Coordinators completed an audit on 2/15/12 to ensure all medications were being stored, labeled and dated properly. Any medications that were not stored properly were moved and stored according to policy. All medications that were not labeled correctly were discarded. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** (1)The Assistant Directors of Nursing and Staff Development will have all active licensed staff reeducated by 3-21-12 on the proper storage, labeling, and dating of medications. (2)Markers were placed in all medication refrigerators to label vials on 2/15/12 by the Assistant Director of Nursing.	2/15/12 2/15/12 3/21/12 2/15/12

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F 431	Continued From page 20 spray medications stored together, without a divider, with four (4) oral liquid medications. The Two South #2 Medication Cart was found to contain four (4) nasal spray medications, one (1) ophthalmic medication and fourteen (14) oral medications all stored together. The Two North #1 Medication Cart had one (1) nasal spray medication stored together with the oral medications in the bottom of the cart. The Two North #2 Medication Cart also had one (1) nasal spray medication stored with liquid oral medications. Observation, on 02/15/12 at 8:30 AM, of the refrigerator located on the second floor in the medication room revealed two (2) opened, undated tuberculin vials. The vial boxes were dated 01/11/12 and 01/13/11, respectively, which was beyond the expiration date for use of an opened vial of medication. Interview, on 02/15/12 at 8:00 AM, with Registered Nurse (RN) #2 revealed nasal sprays were not to be stored together with oral medications. She stated they were to be divided. Interview, on 02/15/12 at 8:05 AM, with Certified Medication Technician (CMT) #1 revealed medications were to be stored separately in the bottom of the cart. She stated the medications were to be divided. Interview, on 02/15/12 at 8:15 AM, with Licensed Practical Nurse (LPN) #6 revealed oral medications were to be stored separate from nasal sprays and ophthalmic drops were to be stored in the top of the cart. She also stated when a medication vial was opened; the vial was	F 431	(3)The Staff Development Coordinator, Assistant Directors of Nursing or Restorative Coordinator will audit medication carts and refrigerators in medication rooms weekly for 24 weeks to ensure medications are being properly stored, labeled, and dated. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained (1) Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated. Include dates when corrective action will be completed. ted. 3/21/12	3/21/12 3/21/12 3/22/12

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F 431	Continued From page 21 to be dated. Interview, on 02/15/12 at 8:30 AM, with CMT #2 revealed nasal sprays were not to be stored with oral medications. Interview, on 02/15/12 at 8:40 AM, with LPN #7 revealed medications were to be stored separate based on the route of administration. She also stated the date a medication vial was opened should be written on the vial. Interview, on 02/16/12 at 1:45 PM, with LPN #5 revealed liquid medications and nasal sprays were to be stored separately and eye drops belonged in the top of the medication cart. She stated the purpose was to not mix the medications up and that it would be bad to spray nose drops into someone's eyes. She had been trained on the separation of medications while stored and the reasons why they are not to be stored together. The nurses at the end of the shift were to monitor the carts, she stated. In addition, she stated medication vials were to be dated when opened. Interview, on 02/15/12 at 2:55 PM, with the Assistant Director of Nursing (ADON) revealed the staff had been trained on the storage of medication. It was revealed medications were to be stored separately based on the route of administration. She stated the correct storage prevents mistakes such as eye drops going into someone's ears. It was revealed once a tuberculin vial was opened it would be good for twenty-eight (28) days, and once opened, the vial was to be dated. She stated the nurses monitor the carts and the medication room and that she	F 431		

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F 431	Continued From page 22 monitors the carts and medication rooms weekly. Continued interview, at 3:45 PM, with the Director of Nursing (DON) revealed the ADON monitors the medication carts and audits are done. She revealed the staff had been in-serviced by staff development on the storage of medications. She stated the importance of having the medication stored separately was to not have an error such as nose drops getting into someone's eyes or the cross contamination of the medications.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F 441 Infection Control, Prevent Spread of Linens Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. (1)The nurse caring for resident #5 was reeducated on 2-15-12 by the Director of Nursing on hand washing policy and procedure. 02/15/12 (2)RN #3 was educated on 2-16-12 by the Director of Nursing on hand washing. 02/16/12 (3) LPN #1 and C.N.A. #8 who were providing care for resident #14 were reeducated on infection control guidelines on 2/16/12 by the DON. 02/16/12	

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F 441	Continued From page 23 direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review related to dressing procedures, handwashing, and suctioning, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for (2) two of (22) sampled residents and for (1) of one (1)unsampled resident. The facility did not ensure proper hand hygiene during dressing changes for Resident #5 and during perineal care for Resident #14. In addition the facility failed to utilize proper infection control techniques in the storage of the suction equipment for unsampled Resident A. The findings include: Review of the facility's policy for Dressing Procedures-Clean Technique, dated 12/10/10, revealed the staff were to remove gloves and wash hands between dressing changes.	F 441	<u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u> (1)All other residents requiring assistance with care or toileting and requiring dressing changes have the potential to be affected. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u> (1)The Director of Nursing and Staff Development Coordinator will have all active licensed staff reeducated on completing dressing changes and skin assessments per infection control guidelines by 3-21-12. (2)The Director of Nursing and Staff Development Coordinator will have all active nursing staff reeducated on proper hand washing including in between changing from soiled gloves to clean gloves by 3-21-12. (3)The Director of Nursing and Staff Development Coordinator will have all active nursing staff reeducated on proper disposal of soiled briefs by 3-21-12. (4)The Director of Nursing and Staff Development Coordinator will have	3/22/12 3/21/12 3/21/12 3/21/12 3/21/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185067	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/16/2012
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F 441	Continued From page 24 Observation of skin assessment and dressing change of Resident #5 on 12/15/12 at 2:40 PM revealed Registered Nurse (RN) #3 removed the old dressing, removed the soiled gloves, but did not wash her hands before reapplying clean gloves. Interview with RN #3, on 02/15/12 at 2:45 PM, revealed she did not know she was suppose to wash her hands when changing gloves from dirty to clean. RN #3 was uncertain what the facility's policy stated and said they were always having inservices on hand washing. She should have known. Interview, on 02/15/12 at 3:45 PM, with the Director of Nursing (DON) revealed the staff was suppose to wash their hands between changing dirty gloves to clean gloves to prevent the transmission of diseases. 2. Review of the facility's policy for Handwashing, dated 12-2010, revealed the staff will wash their hands as necessary to prevent the spread of infections or germs. The facility did not provide evidence of policies regarding perineal care and infection control as requested. Clinical record review for Resident #14 revealed the facility admitted the resident on 02/10/12 with a diagnosis of Clostridium Difficile (C-Diff) in the stool. During observation of Resident #14, on 02/15/12 at 2:00 PM, revealed LPN #1 and CNA #8 washed their hands and applied clean gloves before performing the skin assessment. The skin	F 441	all active nursing staff reeducated on removing of soiled gloves before touching clean skin and clean surfaces by 3-21-12. (5)The Director of Nursing and Staff Development Coordinator will have all active licensed staff reeducated on the storage and cleaning of suction equipment including suction catheters and suction canisters by 3-21-12. (6) The Staff Development Coordinator will observe two dressing changes per week for 24 weeks to ensure infection control guidelines are being followed. (7)The Assistant Director's of Nursing will observe two skin assessments per week times for 24 weeks to ensure infection control guidelines are being followed. (8)The Restorative Coordinator will observe a C.N.A. change an incontinence brief two times per week for 24 weeks to ensure infection control guidelines are being followed including hand washing, removing soiled gloves timely, and appropriate disposal of soiled briefs. (9)The Central Supply Coordinator will audit suction equipment, suction	3/21/12 3/21/12 3/21/12 3/21/12 3/21/12

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NAME OF PROVIDER OR SUPPLIER: SUNRISE MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 80 PHILLIPS LANE, HODGENVILLE, KY 42748

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F 441	Continued From page 25 assessment of the resident's buttocks revealed the resident's brief was soiled with feces and the resident needed perineal care and a brief change. The CNA cleansed the perineal area with wipes. The LPN squeezed moisture barrier cream onto the soiled gloved hand of the CNA who applied the moisture barrier cream to the resident's buttocks. The CNA laid the soiled brief on the top of the bedspread. The LPN and CNA placed the clean brief under the resident's buttocks. The resident then urinated and the LPN cleansed the front perineal area with wipes. The CNA opened the closet door to get a clean brief while wearing the soiled gloves. The CNA then removed the soiled gloves and reapplied clean gloves without washing her hands. The LPN and CNA removed the urine soaked brief and reapplied the clean brief. The LPN repositioned the resident in bed and pulled up the resident's blanket while wearing the soiled gloves. Interview with CNA #1, on 2/15/12 at 2:20 PM, revealed she was not aware of opening the closet door with the soiled gloves still on. CNA 1# said she should have washed her hands and put on clean gloves when going from dirty to clean. They have inservices on this all the time. She stated she could have spread germs. Interview with LPN #1, on 02/15/12 at 3:30 PM, revealed she was aware that she should have washed her hands and changed gloves more often through out the procedure. LPN #1 said she did not know what she was thinking. She was very nervous and they were not expecting the resident to urinate and the need for the brief changes. She was uncertain when they were last inserviced on dressing changes.	F 441	catheters, and suction canisters for proper storage and changing of equipment weekly for twelve weeks. (10)Hand washing competencies will be completed on all active nursing staff by the Director of Nursing, Assistant Directors of Nursing and Staff Development Coordinators by 3-21-12. (11)Hand washing competencies will be completed annually for all nursing staff and as needed. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** (1) Findings of the above stated audits will be reviewed by the QA committee monthly for 6 months for recommendations and further follow-up as indicated. **Include dates when corrective action will be completed.** 03/22/12	3/21/12 3/21/12 3/21/12 3/22/12

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F 441	Continued From page 26	F 441		

Interview, on 02/15/12 at 3:45 PM, with the DON revealed the facility's procedure for preventing the spread of C-Diff was handwashing and glove changing. The staff should have placed the soiled briefs in a plastic bag, not on the resident's bed covers. This could cause the transmission of disease. The staff should always wash their hands and change gloves when going from dirty to clean.

3. Review of the facility's policy Suctioning (Revised August 2011) revealed a suction canister should be emptied and cleaned daily. There was no infection control procedure in place that addressed the storage of the contaminated Yankauer catheter suction device.

Interview, on 02/16/12 at 3:45 PM, with the Director of Nurses (DON) revealed suction equipment was stored in the resident ' s room with a bag over it. The canister was changed once a week and the Yankauer suction catheter was stored in a package when not in use to prevent contamination. She stated this was changed weekly and dated when changed. It was stated the nurse was to monitor the suction equipment and Central Supply did audits. She was unsure if in-services had taken place on suction equipment.

Observation, on 02/14/12 at 9:00 AM, during the facility tour revealed an uncovered, undated Yankauer suction catheter placed on a table in the room of Unsampled Resident A, still connected to the suction canister. The suction canister was uncovered and the products of

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F 441	Continued From page 27 suctioning remained inside the canister. Observation, on 02/14/12 at 5:00 PM, revealed no change in the suction canister or the Yankauer suction catheter in the room of Unsampled Resident A. Observation, on 02/15/12 at 10:25 AM, 2:10 PM, 3:05 PM, and 3:45 PM, revealed the same suction canister with the previous products of suctioning and the Yankauer suction catheter remained unchanged, had not been cleaned, covered or moved in the room of Unsampled Resident A. Interview, on 02/16/12 at 2:30 PM, with Licensed Practical Nurse LPN #3 revealed equipment for suctioning was to be stored covered and the Yankauer suction catheter was to be placed back in its cover. She stated the suction canister was to be emptied after use and was replaced by the oxygen people that maintain the equipment. The Yankauer suction catheter was to be dated, she said. She had not received training within the facility on how to care for suction equipment, she stated. She revealed the nurses monitored the suction equipment and the Assistant Director of Nurses (ADON) monitored the nurses. Interview, on 02/16/12 at 2:35 PM, with LPN #4 revealed a plastic cover was to be placed over the entire suction equipment unit and the canister was to be emptied immediately after use and then replaced. As noted, the suction equipment was not observed covered. She stated the package the Yankauer suction catheter came in was dated and the charge nurse monitors the suction equipment. She revealed she attended an	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR	80 PHILLIPS LANE HODGENVILLE, KY 42748

(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 441	Continued From page 28 in-service about a year ago on suction equipment.	F 441		

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 02/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. BUILDING 02 - SUNRISE MANOR NURSIN B. WING _____	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR	80 PHILLIPS LANE HODGENVILLE, KY 42748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 02 PLAN APPROVAL: 2011 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: New, two (2) stories with a partial basement, Type II (000) construction. SMOKE COMPARTMENTS: Five (5) on the first floor and three (3) on the second floor. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Automatic (wet) sprinkler system, hydraulically designed. GENERATOR: Type II generator, fuel source is diesel. A Life Safety Code survey was conducted on 02/14/12. Sunrise Manor Nursing Home was found to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: x NHA (X6) DATE: 3/15/12

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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