

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

PRINTED: 04/10/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/27/2015
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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 000	INITIAL COMMENTS  A Recertification Survey and Abbreviated Survey (KY#22936) was conducted on 03/24/15 through 03/27/15 with deficiencies cited at the highest scope and severity of an "E". KY#22936 was substantiated with deficiencies cited.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dan Stockdale</i>	TITLE <i>Interim Administrator</i>	(X6) DATE <i>4/20/15</i>
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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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F 157	Continued From page 1 legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to notify the physician of the need to alter treatment for two (2) of sixteen (16) sampled residents (Resident #9 and Resident #3). Resident #9 was ordered a "now" dose of Decadron (corticosteroid) on 03/04/15 and the facility failed to notify the physician when the medication was not administered. Resident #3 was diagnosed with a rash on 03/03/15 and medication and treatment was ordered for five (5) days. The resident was re-assessed on 03/11/15 and new orders were obtained for topical ointment and a referral was ordered for the resident to see a dermatologist. On 03/24/15, the resident continued to have visible signs of itching and there was no documented evidence that the consult with the dermatologist had been obtained or that the physician had been updated on the resident's condition.  The findings include:  Interview with the Directive of Nursing, on 03/27/15 at 11:30 AM, revealed the facility does not have a policy specific to physician notification.  Review of the facility's Medication Administration Policy, not dated, revealed the physician should be notified of changes in condition related to the medication regimen (improvement or decline).  1. Record review revealed the facility admitted Resident #9 on 11/20/13 with diagnoses which	F 157	as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.  F157 The physician was notified of the medication error for resident # 9 by the Unit Manager on 03/05/2015. On resident #3 the physician was notified of the daughters refusal for the dermatology consult on 03/25/2015 by the Unit Manager. A new dermatologist was found and agreed upon by the family and an appointment has been scheduled for 4/28/15. 2. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete an audit of all current resident's physician orders for the past thirty days to determine if all physicians orders were carried out. Any identified as not being completed will have physician notification and further direction. This will be completed by May 10 <sup>th</sup> 2015. 3. All licensed staff will be re-educated on notification of the physician if they are	5/11/15

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F 157	<p>Continued From page 2</p> <p>included Anxiety, Hypothyroidism, Hypertension and Conjunctivitis.</p> <p>Review of a Physician's Order Sheet, dated 03/04/15 at 2:25 PM, revealed a telephone order for Decadron 4 milligrams (mg) intramuscular (IM) now.</p> <p>Review of Nurses Note, dated 03/04/15 at 5:06 PM, revealed the physician was notified the resident had a rash to upper chest, arms and legs. New orders were received for Decadron 4 mg IM now, Medrol dose pack and Zyrtec 10 mg by mouth for seven (7) days. Further review of the Nurse's Note revealed the Decadron was not in the Emergency Drug Kit (EDK), so the pharmacy was notified the Decadron was needed stat.</p> <p>Review of the March 2015 Medication Administration Record (MAR) revealed the now dose of Decadron 4 mg IM was not administered until 03/05/15 at 6:30 PM, after discovery of the omission by the Unit Manager.</p> <p>Review of the Medication Error form, dated 03/05/15, revealed the now dose of Decadron was noted received from the pharmacy and was not given as ordered. Further review revealed Resident #9's physician was notified of the error on 03/05/15 at 3:00 PM by the Unit Manager.</p> <p>Post survey interview with LPN #4, on 04/10/15 at 9:32 AM, revealed she had been notified by other staff that Resident #9 had a rash and when she assessed the resident, the resident was digging and scratching at his/her skin. LPN #4 stated she then phoned the physician and received new orders to administer a now dose of Decadron 4</p>	F 157	<p>unable to follow physician orders including consultations. This education will be conducted by the Director of Nursing, Assistant Director of Nursing or Unit Managers and will be completed by 05/10/2015 with no licensed staff working after 05/10/2015 without having receiving this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manger will audit five resident's medical records per week for twelve weeks to determine if physician orders have been carried out and if unable to carry pout the physician orders that the physician was notified. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least Quarterly.</p>		

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F 157	<p>Continued From page 3</p> <p>mg IM. LPN #4 revealed she checked the Emergency Drug Kit (EDK) and there was no Decadron in the box so she faxed the order to the pharmacy and followed up with a phone call. She stated she spoke with a female at the pharmacy and notified her that she needed the Decadron stat and the female asked if it could be delivered with the nine (9) PM medications. LPN #4 revealed she told the female she needed the medication stat. LPN #4 stated the medication had not arrived by the time her shift ended at 7:00 PM so she reported that to the oncoming staff. LPN #4 stated she was not aware the medication was not delivered until the next day until approximately a week later. The LPN revealed she did not notify the physician before she left that the medication had not been received. She stated, "I should have called the pharmacy before I left".</p> <p>Interview with Unit Manager, on 03/26/15 at 2:00 PM, revealed the original nurse on duty received the order from the physician and she faxed and called the pharmacy to let them know the medication needed to be sent to the facility stat for administration. The Unit Manager stated the medication was not kept in the EDK. The Unit Manager revealed the dose should have been received within an hour; however, the medication wasn't received by the facility until 03/05/15 (next day). The Unit Manager administered the Decadron at 6:30 PM on 03/05/15.</p> <p>Interview with Resident #9's Physician, on 03/26/15 at 2:52 PM, revealed she was not notified of the delay in giving the now dose of Decadron. The Physician stated the facility should have obtained the medication from another source, if needed. The Physician</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>revealed she expected the medication to be administered in a timely manner. and to be notified the condition of the resident's rash. The physician stated the resident was "suffering" with a rash.</p> <p>2. Record review revealed the facility admitted Resident #3 on 04/15/09 with diagnoses which included Hypertension, Anxiety, Alzheimer's Disease, and Rash. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/05/15, revealed the facility identified the resident's cognitive status as severely impaired with a Brief Interview of Mental Status (BIMS) score of "99" which indicated the resident was not interviewable.</p> <p>Review of the Change of Condition Process policy, last revised 09/2013, revealed an staff should notify the physician immediately of any symptom, sign or apparent discomfort that is acute or sudden in onset, and if there is a marked change (ie more severe) in relation to usual symptoms and signs, or it is unrelieved by measures already prescribed.</p> <p>Review of a Nursing Note, dated 03/03/15 at 5:15 PM, revealed Resident #3 was diagnosed with a rash on 03/03/15 and ordered an oatmeal bath daily for five (5) days and Benadryl (antihistamine) 25 milligram (mg), one pill by mouth (PO) three times (tid) a day for ten (10) days.</p> <p>Review of a Physician Order, dated 03/11/15, revealed the physician was notified on 03/11/15 of continued rash and new orders were obtained for a topical ointment and a referral was ordered for the resident to see a dermatologist.</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>Interview with Registered Nurse (RN) #2, on 03/25/15 at 8:30 AM, revealed he called the dermatologist office to schedule the appointment on 03/13/15, and was told the provider was not able to bill the resident's insurance. He stated he talked with the resident's daughter, notified her of the problems with scheduling the appointment, and she wanted to look for another medical provider on her own. He continued to reveal he was waiting for a response from the resident's daughter before he notified the medical provider.</p> <p>Review of Resident's medical record revealed there was no documented evidence that the resident's physician was notified that the consult with the dermatologist had not been obtained.</p> <p>Observation on 03/24/15 at 11:30 AM, and again on 3/25/15 at 10:30 AM, revealed Resident #3 was visibly scratching legs and lower back and buttocks while sitting up in geri-chair in the hallway. On 03/24/15 at 1:35 PM, a skin assessment was completed on Resident #3, and revealed multiple red raised areas to the upper and lower extremities, trunk and buttocks. Further observation revealed there were visible areas of red scratch marks noted on the hips and buttocks.</p> <p>Interview with Assistant Director of Nursing (ADON), on 03/24/15 at 2:20 PM, revealed she was aware the resident had a rash for a couple of weeks. She stated an appointment was scheduled with the Dermatologist but was cancelled because they were unable to bill the resident's insurance and she was not sure what the resident's daughter wanted to do. She further revealed she was unaware of any other</p>	F 157		
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F 157	Continued From page 6 intervention in place other than the topical ointment for the rash.  Interview with the Director of Nursing (DON), on 03/24/15 at 8:05 AM, revealed she was not aware the appointment was cancelled for the resident to see the Dermatologist. She stated they needed to find a dermatologist that will accept the residents health insurance. She further revealed they were waiting for the resident's daughter to contact them related to scheduling an appointment.  Interview with Resident #3's Physician, on 03/25/15 at 11:45 AM, revealed he was not aware the ointment was not effectively treating the rash. He further stated that the resident could be placed on an oral medication for itching if it was necessary. He continued to reveal he had not been updated on the residents condition and should have been updated if the treatment was not working. He also revealed he was not aware the dermatologist consult had not been scheduled per his order.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure care for residents in a manner and in an environment that	F 241	F241 1. The nails of unsampled resident B were cleaned and trimmed by the MDS Assistant on 03/24/2015. The Geri chair for resident # 3 was cleaned on 03/25/2015 And the resident's nails were cleaned and trimmed on 03/24/2015 by MDS Assistant. The Bed side commode for resident # 14 was emptied and cleaned on 03/24/2015 by	5/11/15	

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F 241	<p>Continued From page 7</p> <p>maintains/enhances resident's dignity and respect in full recognition of his/her individuality for two (2) of sixteen sampled residents (Resident #3 and Resident #14) and one (1) unsampled resident (Unsampled Resident B).</p> <p>The findings include:</p> <p>Review of facility's Dignity Policy and Procedure which was chapter one (1), "OBRA-Required Actions to Promote Dignity and Privacy", out of (Mosby's Textbook for Long-Term care Nursing Assistants) fifth edition, revealed that nursing centers must care for residents in a manner that promotes dignity and self-esteem.</p> <p>1. Record review revealed the facility admitted Unsampled Resident B on 01/27/15 with diagnoses which included Pleural Effusion, Encephalopathy, Hypertension, Esophageal Reflux, Dementia NOS, Hyperlipidemia, Thyroid Disorder, Open wound of buttocks, and Deficient Anemia. Review of the Admission Minimum Data Set (MDS) assessment, dated 02/03/15, revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of "4" indicating the resident was not interviewable. In addition, the resident required the extensive assistance of two (2) persons physical assist needed for personal hygiene cares.</p> <p>Observation of Unsampled Resident B, on 03/24/15 at 1:55 PM, revealed he/she had long dirty finger nails to both hands.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 03/27/15 at 7:50 AM, revealed expectations for nail care were for nails to be trimmed, cleaned</p>	F 241	<p>MDS Assistant.</p> <p>2. On 04/17/2015 the Assistant Director of Nursing, Unit Managers, MDS Coordinator, and the MDS Assistant completed an audit of all resident's wheel chairs or geri chairs and finger nails to identify any that were unclean or nails that needed trimming. Any identified had the chair cleaned immediately and or nails cleaned and trimmed immediately. An audit of all Bed Side commodes was completed on 03/25/2015 by the MDS Assistant to identify any that were unclean, needed emptying or had an odor. Any identified were immediately emptied and or cleaned.</p> <p>3. On 04/13/2015 the Administrator re-educated the Department Heads consisting of the Director of Nursing, the Assistant Director of Nursing, the Unit Managers, MDS Coordinator, the MDS Assistant, Social Service Director, Staff Development Coordinator, Dietary Services</p>	
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F 241	<p>Continued From page 8</p> <p>and/or filed as needed because residents eat with their hands. She further stated nail care was supposed to have been done on bath days and whenever necessary.</p> <p>Interview with CNA #2, on 03/27/15 at 7:55 AM, revealed expectations for nail care was it should have been checked daily for need and done on bath days.</p> <p>Interview with Unit Manager Licensed Practical Nurse (LPN) #1, on 03/24/15 at 2:00 PM, revealed nail care should have been done with showers and the charge nurses and unit managers were responsible to ensure nail care was completed. LPN #1 stated she expected the residents to have had nail care with each shower and or bed bath along with as needed in between shower/bath days.</p> <p>Interview with Director of Nursing (DON), on 3/26/15 at 1:00 PM, revealed he/she expected routine nail care to be done on all residents. The DON stated all nurses, unit managers, and administrative nurses should check and make sure nail care was being done. The DON revealed nail care was absolutely very important and should have been done routinely without exception unless there had been a contraindication or physician's order not to perform nail care.</p> <p>2. Record review revealed the facility admitted Resident #3 on 04/15/09, with diagnoses which included Hypertension, Anxiety, Alzheimer's Disease, and Rash. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/05/15, revealed the facility identified the resident's cognitive status as severely impaired</p>	F 241	<p>Manager, Maintenance Director, and Medical Records Coordinator on conducting room rounds on assigned residents to include checking cleanliness of chairs, fingernails and that bed side commodes are emptied timely. The Department Heads will conduct rounds five times per week to identify any concerns with nail care, unclean chairs or bedside commodes not clean or empty. The results of these rounds are reviewed during the morning meeting. All current nursing assistants will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Managers on completing nail care on shower days as well as emptying/ rinse bedside commodes on each round. All night shift nursing assistants will be re-educated on the cleaning schedule for wheel chairs and geri chairs.</p> <p>4. The Administrator will audit 10 residents per week for twelve weeks to</p>	
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F 241	<p>Continued From page 9 with a Brief Interview of Mental Status score of "99" which indicated the resident was not interviewable.</p> <p>Observation of Resident #3, on 03/24/15 at 9:35 AM, revealed the resident was in a geri-chair reclined, with the chair alarm visible on back of chair, physically leaning to the left with pillow under left side. There was facial hair visible to the chin and cheek area and his/her finger nails were long with a visible yellow substance under his/her nails. Further observation revealed a large amount of brown dried substance to both sides of the chair and on the right chair arm .</p> <p>Observation of Resident #3, on 03/25/15 at 7:35 AM, revealed the was resident in the geri-chair in the main dining room at the dining table. Further observation revealed the geri-chair continued to have visible soiled areas to each side and on the hand rests and the resident's nails remained long with visible substance under nails.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 03/27/15 at 7:50 AM, revealed she knew the resident's wheelchair was washed down last Wednesday with a bleach wipe because she asked the staff to do it. She stated the chair looked "nasty" at that time. She revealed she had not seen them clip his/her nails and understands why that could be a problem for the resident related to infection control issues and appearance.</p> <p>Interview with Registered Nurse (RN) #5, on 03/27/15 at 11:30 AM, revealed there was a chair cleaning schedule in the shower room and the Certified Nursing Assistants (CNA'S) were supposed to clean the chairs according to the</p>	F 241	<p>determine if department heads are identifying concerns with nail care, clean chairs and emptying of bedside commodes. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>	

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F 241	<p>Continued From page 10</p> <p>schedule. She stated she had not clipped the resident's nails and continued to state "I need to keep on top of that". She was not aware when the last time the resident's chair had been cleaned.</p> <p>Interview with RN #4, on 03/26/15 at 8:45 AM, revealed there was not a specific site on the resident's Treatment Flow Sheet for nail care. She stated when the staff conduct the resident's scheduled body audit the nails should be monitored and documented on the skin assessment flow sheet. RN #1 revealed she realized the importance of nail care due to the resident's frequent scratching as well as his/her appearance. She stated the resident remains in the geri-chair all the time and was not placed in the bed at night at the resident's daughters request. She further revealed the Unit Manager was responsible to do audits of the Medication Administration Records (MAR's) and the Treatment Administration Records (TAR'S) as well as skin assessments to ensure care is being provided.</p> <p>Interview with RN #2 Unit Manager, on 03/26/15 at 9:00 AM, revealed he was not aware Resident #3's geri-chair was visibly dirty and his/her finger nails needed trimming. He stated nail care should be addressed with bathing and skin assessments weekly and the care of nails and shaving should be completed with baths. He further revealed he expected the staff to complete nail care and shaving during the bath or for staff to notify their charge nurse if they were unable to complete the assignment. He further stated the eleven to seven (11-7) shift is responsible for cleaning the wheelchairs and geri-chairs.</p>	F 241		

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F 241	<p>Continued From page 11</p> <p>Interview with Housekeeping Supervisor, on 03/26/15 at 10:05 AM, revealed the 11-7 shift was responsible to keep the wheel chairs and geri chairs clean. She stated the facility has a system in place where each resident is assigned a Caring Partner to go into the resident's room each morning and look at the resident's environment as well as the resident to make sure the resident's care needs are being met.</p> <p>Interview with Director of Nursing (DON), on 3/26/15 at 12:40 PM, revealed the Caring Partners are administrative staff that are assigned to a group of residents and they are expected to make rounds on the residents each morning before morning meeting. She stated they are expected to check the resident's room for safety issues, dignity issues, environmental concerns, cleanliness of the resident, and grooming needs of the resident. She revealed they have a check sheet that is filled out each morning during their tour of rooms. She stated she would have expected the residents caring partner to have identified any concern and either fixed the problem or reported it to the appropriate staff. She further stated if the caring partner was a clinical staff member she would have expected them to have clipped the residents nails or performed whatever service that was needed at the time.</p> <p>3. Record review revealed the facility admitted Resident #14 on 02/02/15 with diagnoses which included Intertrochanteric Fracture, Chronic Kidney Disease, Diabetes Mellitus Type II, Hypertension, Difficulty in Walking. Review of the Admission MDS assessment, dated 02/09/15, revealed the facility identified the resident as being cognitively intact with a Brief Interview for</p>	F 241			

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F 241	<p>Continued From page 12</p> <p>Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review revealed the facility identified the resident was frequently incontinent of bowel and bladder and required two (2) person physical assist for transfer, bathing, grooming and toileting assistance.</p> <p>Observation of Resident #14, on 03/24/15 at 9:00 AM, revealed the resident was laying in bed on his/her back, face was flushed, and the call light was in reach. Further observation revealed a commode chair at the resident's bedside with visible urine in the bucket.</p> <p>Interview with Resident #14, on 03/24/15 at 9:00 AM, revealed the resident had used the commode chair last night and it had not been emptied. He/She stated the room smelled like urine and he/she wished they would empty it. The resident revealed he/she was going to be discharged on Saturday and could not wait to get home.</p> <p>Interview and observation of Resident #14 on 03/24/15 at 2:10 PM, revealed the commode chair remained at the bedside with visible urine in the bucket. Upon entering the resident's room a urine odor was detected. Resident #14 stated "they have not emptied my pot today". The resident stated he/she only used the bedside commode at night because during the day he/she goes to the bathroom.</p> <p>Interview and Observation of Resident # 14, on 03/25/15 at 9:40 AM revealed the commode chair remained at the bedside with visible urine in the bucket and the room continued to have a detectable urine odor. The resident revealed that</p>	F 241		
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F 241	<p>Continued From page 13</p> <p>he/she did not use it last night because of the smell and the fact that it had old urine in it. She stated it should be obvious that the bucket needed emptying because of the smell. Resident #14 continued to apologize for the urine odor in the room.</p> <p>Interview and observation of Resident # 14, on 03/26/15 at 9:10 AM, revealed the bedside commode remained in the resident's room with urine visible in the bucket. The resident revealed he/she had to use it last night because she was afraid she would fall attempting to go to the bathroom and that it had not been emptied all week.</p> <p>Further observation, on 03/26/15 at 9:30 AM with LPN #6 who was Resident #14's assigned caring partner, revealed the bedside commode remained at the resident's bedside with visible urine in the bucket. LPN #6 removed the lid to the bucket and revealed contents to be half full urine. Interview with Licensed Practical #6 at the time revealed she was Resident #14's assigned caring partner. LPN #6 stated some of her responsibilities for the resident included making sure things were put away, and the resident had toilet paper, tissues, and paper towels in the bathroom. LPN #6 revealed it was important to make sure any dignity issues were addressed, incontinent pads were out of sight and that all the equipment was clean and working properly. LPN #6 stated she was not at work yesterday but she checked the resident's room this morning and had no concerns.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 03/27/15 at 8:35 AM, revealed they make buddy rounds at the start and end of each shift</p>	F 241		

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F 241	<p>Continued From page 14 with off going staff to make sure each resident is clean. She continued to reveal that she did not realize the commode chair had been used.</p> <p>Interview with CNA #5, on 03/27/15 at 8:40 AM, revealed she normally checks the rooms with rounds. She stated the resident uses the bathroom on our shift and she didn't realize the commode chair had been used. She further revealed the resident uses the commode chair at night and the night shift should be checking the commode chair.</p> <p>Interview with Director of Nursing (DON), on 03/26/15 at 9:10 AM, revealed the nursing assistants should have emptied the commode chair. She continued to reveal that the facility has staff assigned (Caring Partners) to each resident to perform room checks each morning to ensure the resident's needs are being met. She continued to reveal they are instructed to make sure the rooms are clean and odor free, dignity issues and safety issues are dealt with. She continued to reveal that if the assigned staff are clinical staff her expectations were they provide the necessary service. Her expectation were they also should have realized the commode chair had not been emptied.</p>	F 241		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>	F 278	<p>F278</p> <p>1. By 04/23/15 the interdisciplinary team (IDT) consisting of the MDS Nurse, Director of Nursing, Assistant Director of Nursing,</p>	5/11/15

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F 278	<p>Continued From page 15</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 3.0 User Manual, it was determined the facility failed to ensure each resident was accurately assessed to reflect their status for one (1) of sixteen (16) sampled residents (Residents #1)</p> <p>The findings include:</p> <p>Review of the RAI MDS 3.0 Manual, revealed when conducting an MDS Assessment staff were to speak with direct care staff from each shift who had cared for the resident to determine his/her needs. Continued review revealed when</p>	F 278	<p>Social Services Director, Dietary Services Manager, Activity Director and Director of Rehab: along with a nursing assistant who cares for the resident will review the most recent OBRA MDS and Medical Record including any current therapy notes for resident # 1 and will evaluate the current ADL needs of the resident to ensure that the care plan meets the needs of the resident. Any changes to the plan of care will be made at that time.</p> <p>2. By 05/10/15 the IDT along with a nursing assistant will review all current resident's most recent OBRA MDS and medical record including any current therapy notes to ensure the ADL plan of care reflects the current needs of the resident. Any needed changes in the plan of care will be noted on the plan of care.</p> <p>3. By 04/24/2015 the Regional Reimbursement Nurse will re-educate the MDS Nurse and the Assistant MDS Nurse on</p>	

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F 278	<p>Continued From page 16</p> <p>reviewing records, interviewing staff and observing the resident; staff conducting the MDS Assessment must be specific when evaluating each component as listed in the Activities of Daily Living (ADL) activity definition. Further review of the Manual revealed for Section G, the Coding Instructions revealed consider each episode of the activity that occurred during the seven (7) day look back period and for the purpose of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff).</p> <p>Review of the RAI MDS 3.0 Manual, revealed the definition for "Walks In Corridor": (how resident walked in corridor on unit) and the definitions for "Locomotion On Unit": (how resident moved between locations in his/her room and adjacent corridor on the same floor. If in wheel chair, self-sufficiency while in chair).</p> <p>Record review revealed the facility admitted Resident #1 on 10/03/14 with diagnoses which included Adjustment Disorder with Depression, Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, Hypothyroidism, Hypertension, Allergic Rhinitis, Esophageal Reflux, and Gastronomy Status.</p> <p>Review of a Quarterly MDS Assessment, dated 02/21/15, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of "15" which indicated he/she was interviewable.</p> <p>Review of Resident #1's Quarterly MDS Assessment, dated 02/21/15, revealed he/she did not walk in coridor during the seven (7) day look</p>	F 278	<p>the requirement to review therapy documentation for ADL coding when therapy services are in place.</p> <p>4. The Regional Reimbursement Nurse will review five OBRA MDS per month for three months to ensure that coding is accurate based on the medical record and any current therapy services. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>	
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F 278	Continued From page 17 back period (2/15/15 through 02/21/15) and his/her locomotion on unit had been coded as limited assistance of one (1) person physical assist.  Review of Resident #1's Physical Therapy Progress Report during the seven (7) day look back period (02/15/15 through 02/21/14), revealed the resident ambulated daily times four (4) out of seven (7) days with extensive assistance of one (1) person physical assist; however, this was not captured on the 02/21/15 MDS assessment.  Interview with MDS Coordinator Licensed Practical Nurse (LPN) #2, on 03/25/15 at 8:40 AM, revealed the coding for ambulation and locomotion for Section G of the MDS had come from the Certified Nurse Aides's (CNA) documentation and he did not get information regarding those areas from the therapy department even for residents that were in therapy during the look back periods for the MDS Assessments. He further stated that he was unaware that therapy had progress notes on residents during the look back period that listed/noted ambulation, locomotion and assistance given by members of the therapy department. He also stated he expected the MDS Assessments to have been coded as accurately as possible and to have reflected a true status of the residents. He further stated he needed to have coordinated with therapy for residents who had been in an MDS assessment period to verify if therapy had provided services for any resident who had been in an MDS Assessment look back period.	F 278			
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279	F279 1. A care plan was developed on 04/15/2015	5/11/15	

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F 279 SS=D	Continued From page 18 <b>COMPREHENSIVE CARE PLANS</b>  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to develop and initiate a care plan for two (2) of sixteen (16) sampled residents, (Resident #2 and Resident #8). The facility failed to develop a comprehensive care plan for Resident #2 related to the administration of medication, digoxin and monitoring for signs and symptoms of digoxin toxicity. In addition, the facility failed to develop a comprehensive care plan for monitoring of the medication Depakote for Resident #8.	F 279	by the Director of Nursing for resident # 2 related to the use of Digoxin and monitoring for adverse effects for the use of medications. A care plan was developed for resident # 8 by MDS Nurse on 04/16/2015 related to the use of Depakote and monitoring for the adverse effects of this medication.  2. By 5-10-2015 the IDT consisting of the MDS Nurse, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager, Activity Director and Director of Rehab: will complete an audit of all current residents to determine if care plans have been developed to meet the needs of the residents to include medications and the monitoring of adverse effects of medications. Any needed care plans will be developed by the IDT at that time.  3. By 04/24/15 the Regional Reimbursement Nurse will re-educate the IDT on	

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F 279	<p>Continued From page 19</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Guidelines for Resident Comprehensive Care Plan" dated 09/08, revealed the resident's comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. Further review revealed the facility should develop care guidelines for Medical Diagnoses and practice standards that can be applied broadly to any resident with the associated diagnoses.</p> <p>Review of Davis Drug Guide for Nurses, Tenth Edition, pages 386-390, revealed nursing implications for digoxin (medication used to slow the heart rate) included assessment to monitor apical pulse for one (1) full minute before administration. Additionally, digoxin should not be administered and the physician should be notified if the apical pulse was less than 60 beats per minute (average adult heart rate is 60-100 beats per minute). Further review revealed digoxin should be used cautiously in the geriatric population and older adults are at increased risk for toxic effects of digoxin. In addition, dosage requirements in the older adult may change and a formerly therapeutic dose can become toxic. Additionally, older adults should be observed for signs and symptoms of toxicity which included abdominal pain, anorexia (loss of appetite), nausea, vomiting, visual disturbances, bradycardia (slow heart rate) and other arrhythmias (irregular heart beat).</p> <p>1. Record review revealed the facility admitted Resident #2 on 10/21/14 with diagnoses which included Congestive Heart Failure, Atrial</p>	F 279	<p>development of care plans to include monitoring of medications.</p> <p>4. The Regional Reimbursement Nurse will review five Resident care plans per month for three months to ensure that care plans are developed to meet the needs of the resident and include monitoring for side effects of medications. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>	
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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 279	<p>Continued From page 20</p> <p>Fibrillation, Chronic Kidney Disease and Diabetes Mellitis.</p> <p>Review of a Physician's Order, dated 10/23/14, revealed Digoxin 0.125 milligrams (mg) every day.</p> <p>Review of the Comprehensive Care Plan for Resident #2, dated 10/21/14, revealed there was no interventions documented regarding the need to obtain the resident's heart rate prior to administration of digoxin and the need to withhold the digoxin if the resident's heart rate was less than 60. Additional review revealed there was no intervention to monitor the resident for signs and symptoms of digoxin toxicity.</p> <p>Review of the March 2015 Medication Administration Record (MAR) revealed there was no documented evidence staff should hold the medication if the pulse was less than 60 beats per minute. Additionally, there was no documented evidence that staff should observe for signs and symptoms of digoxin toxicity.</p> <p>Interview with the Unit Manager, Registered Nurse (RN) #2, on 03/26/15 at 12:30 PM, revealed it was important to monitor for signs and symptoms of digoxin toxicity and to monitor the pulse before administering the digoxin and this should have been included in the resident's care plan.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, LPN #2 on 03/27/15 at 11:10 AM, revealed it was his responsibility to develop the Comprehensive Care Plan and to review and update the care plan quarterly, and as needed to ensure the care plan was individualized and</p>	F 279			

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F 279	<p>Continued From page 21</p> <p>comprehensive to address all the resident's nursing care needs. He stated he did not develop care plans for specific medications and as long as the care plan stated somewhere "meds and labs as ordered" he thought it was okay. He stated he was aware of the need to monitor the medication digoxin and It should have been in the care plan.</p> <p>Interview with the Director of Nursing (DON), on 03/26/15 at 2:25 PM, revealed medications which needed monitoring should be included in the comprehensive care plan. She further stated it was her expectation, staff were to follow the care plan.</p> <p>Interview with the facility's Consultant Pharmacist, on 03/27/15 at 10:40 AM, revealed signs and symptoms of digoxin toxicity could include cardiac arrhythmias, slowing of the heart rate, yellowing vision, slurred speech, and nausea and vomiting. He further stated it would be important to monitor the resident's heart rate before administration and not to administer if the resident's heart rate was less than 60 due the medications effect on slowing the heart rate.</p> <p>2. Record review revealed the facility admitted Resident #8 on 08/04/15 with diagnoses which included Congestive Heart Failure, Morbid Obesity and Epilepsy.</p> <p>Review of the Physician's Order, dated 12/15/14, revealed an order for Depakote Extended Release 500 milligrams (mg) tablet, give two (2) tablets by mouth (PO) twice daily (BID).</p> <p>Review of the Comprehensive Care Plan for Resident #8, dated 03/31/15, revealed there were</p>	F 279		
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F 279	<p>Continued From page 22</p> <p>no intervention documented related to the resident's Epilepsy diagnosis or any interventions to monitor for signs and symptoms of seizures. Further review revealed there were no interventions documented regarding the need to obtain Depakote levels or to monitor for signs and symptoms of drug toxicity.</p> <p>Interview with Licensed Practical Nurse #7, on 03/26/15 at 3:15 PM, revealed she was not aware the resident did not have a specific care plan for Epilepsy or that the resident was not getting any lab levels drawn. She stated she was aware of the signs and symptoms of adverse effect of the medication. She revealed nurses were required to check the care plan each shift for any changes in the resident's treatment plan or condition.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, LPN #2, on 03/26/15 at 11:10 AM, revealed it was his responsibility to develop the Comprehensive Care Plan and to review and update the care plan each quarter. He revealed he did not develop care plans for specific medications that as long as the care plan stated somewhere "meds and labs as ordered" he thought it was acceptable. He was not aware the resident was not getting Depakote levels drawn.</p> <p>Interview with Director of Nursing (DON), on 03/26/15 at 12:40 PM, revealed she was not aware the resident did not have an order to obtain Depakote levels. She further revealed she would have expected labs to have been ordered upon admission and included on the resident's comprehensive care plan. She stated it was important to monitor the drug levels of the residents and also monitor for signs and symptoms of drug toxicity.</p>	F 279			

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F 279	Continued From page 23	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</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:</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing on 04/15/2015 reviewed and updated the fall care plan to include all interventions for falls for resident # 1. By 04/25/2015 the Dietary Service Manager will review and update the nutrition care plan for resident # 7 to include current diet and needed feeding assistance.</li> <li>2. By 05/10/15 the IDT consisting of the MDS Nurse, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager, Activity Director and</li> </ol>	5/11/15

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F 280	<p>Continued From page 24</p> <p>Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure comprehensive care plans were reviewed and revised by a team of qualified persons after each assessment for two (2) of sixteen sampled residents (Resident #1 and Resident #7). Resident #1 sustained falls on 11/06/14 and 01/14/15 and the facility failed to revise the care plan after each fall. Resident #7 had a change in diet and with the amount of assistance needed for feeding and the facility failed to revise the care plan.</p> <p>The findings include:</p> <p>Review of facility's guidelines on Resident Comprehensive Care Plan's, dated 09/08, revealed the residents comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility and the comprehensive care plan should always have realistic goals and approaches/interventions to address the residents' needs.</p> <p>1. Record review revealed the facility admitted Resident #1 on 10/03/14 with diagnoses which included Adjustment Disorder with Depression, Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, Hypothyroidism, Hypertension, and Allergic Rhinitis. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 02/21/15, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 which indicated he/she was interviewable. Further review of the MDS, revealed he/she had not had any falls since previous MDS and the resident</p>	F 280	<p>Director of Rehab will review all current residents care plans to determine if the care plans are up to date and reflect current interventions and needs of the resident. Any changes to the plan of care will be made at that time.</p> <p>3. By 04/24/15 the Regional Quality Manager will re-educate the IDT on updating of care plans with new interventions in the daily clinical meeting.</p> <p>4. The Director of Nursing will review five (5) resident care plans per month for three months to determine if the care plan has been updated with interventions to reflect the current needs of the resident. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance</p>	

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F 280	<p>Continued From page 25</p> <p>required limited assistance of one (1) staff for locomotion on unit.</p> <p>Review of an Incident Report, dated 11/06/14, revealed Resident #1 had a fall when he/she tried to transfer self without assistance. The post incident actions report on 11/06/14 had a new intervention to educate and encourage resident to wait for assistance. However, review of the Comprehensive Care Plan for falls, dated 10/13/14, revealed the care plan was not revised to include this intervention.</p> <p>Review of a Incident Report, dated 01/14/15, revealed Resident #1 was found laying on ramp in the hallway with a laceration to the back of head. Accompanying "CAA" falls worksheet, dated 01/15/15, revealed Resident #1 was propelling self to room and when navigating the incline wheelchair tipped backwards. An intervention of adding anti-tippers to his/her wheelchair was listed both on the Fall Investigation Worksheet and "CAA" Falls worksheet, dated 01/15/15. However, further review of the Comprehensive Care Plan revealed the intervention was not on the care plan.</p> <p>2. Record review revealed the facility admitted Resident #7 on 07/09/02 with diagnoses which included Cerebral Vascular Accident, Hemiplegia, Brain Condition, Schizophrenia, Peripheral Vascular Disease, Altered Mental Status, Hypertension, and Aphasia.</p> <p>Review of MDS assessment, dated 01/25/15, revealed a the facility assessed Resident #7's cognition as severely impaired with a BIMS score of zero (0) which indicated he/she was not interviewable. Further review of the MDS,</p>	F 280	<p>Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>	

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F 280	<p>Continued From page 26</p> <p>revealed he/she was coded as had coughing or choking during meals or when swallowing medication.</p> <p>Review of Comprehensive Care Plan for risk for alteration in nutrition, dated 11/05/14, revealed the resident was to be spoon fed by staff and on 01/17/15 an intervention was added for a peg tube/tube feeding along with nothing by mouth (NPO) diet.</p> <p>Review of a Physician's Telephone Order, dated 01/29/15, revealed to discontinue nothing by mouth (NPO) status, change to pureed diet and thin liquids, and no mashed potatoes or pureed bread. However, further review of the Comprehensive Care Plan for risk for alteration in nutrition, dated 11/05/14, revealed the interventions were not added to the care plan.</p> <p>Interview with MDS Coordinator Licensed Practical Nurse (LPN) #2, on 3/26/15 at 2:30 PM, revealed he expected the care plans to have reflected an accurate up to date picture of the residents. The MDS Coordinator stated temporary care plans were implemented on admission as part of the admission process; care plans were then created with the admission MDS assessments and were looked at quarterly and annually. The MDS Coordinator revealed all the nurses were responsible for making sure the care plans were up to date and accurate and then of course the other disciplines were responsible for croplands that relate to their areas.</p> <p>Interview with Director of Nursing (DON), on 03/26/15 at 8:05 AM, revealed she expected all disciplines to update care plans. The DON stated the care plans should be updated with all new</p>	F 280			

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F 280	Continued From page 27 interventions, changes in goals and discontinued interventions.	F 280			
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 interview, record review, review of the Davis Drug Guide for Nurses, review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided or arranged by the facility were provided according to acceptable standards of clinical practice for three (3) of sixteen (16) sampled residents (Resident #2, Resident #5, and Resident #9). Resident #2 was administered Digoxin (medication to slow the heart rate) without monitoring of the resident's heart rate prior to the administration of the medication and Resident #9 was not administered Decadron (corticosteroid) Intramuscularly (IM) Now according to the physician order. In addition, the facility failed to follow appropriate infection control practices during wound care and failed to provide treatment as ordered by the physician for Resident #2 and Resident #5.  The findings include:  1. Review of Davis Drug Guide for Nurses, Tenth Edition, pages 386-390, revealed nursing implications for digoxin (medication used to slow	F 281	F281 1. An observation by the Director of Nursing on 04/15/2015 noted that the pulse for resident # 2 was monitored prior to administration and the physicians order contained instructions to hold if pulse less than 60. An observation of wound treatments to resident # 2 and #5 by the director of nursing on 04/16/2015 noted that treatments were applied per physician order and appropriate infection control standards were used. The ordered Decadron for resident # 5 was administered by a licensed nurse on 03/05/2015. The Director of Nursing on 04/15/15 provided one on one re-education with LPN # 4 related to hand washing and infection control practices with wound care and following physician orders for treatments. 2. By 05/10/2015 an audit	5/11/15	

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F 281	<p>Continued From page 28</p> <p>the heart rate) included assessment to monitor apical pulse for one (1) full minute before administration. Additionally, digoxin should not be administered and the physician should be notified if the apical pulse was less than 60 beats per minute. Further review revealed digoxin was to be used cautiously in the geriatric population and older adults are at increased risk for toxic effects of digoxin. In addition, dosage requirements in the older adult may change and a formerly therapeutic dose can become toxic. Additionally, older adults should be observed for signs and symptoms of toxicity which included abdominal pain, anorexia (loss of appetite), nausea, vomiting, visual disturbances, bradycardia (slow heart rate) and other arrhythmias (irregular heart beat).</p> <p>Review of the facility's policy and procedure titled "Medication Administration", not dated, revealed staff should provide safe administration of all medications and administer medication according to state specific regulations. Further review revealed staff administering medication should perform necessary assessments prior to administering specific medication per the physician's order which included obtaining the pulse and obtaining the blood pressure.</p> <p>Record review revealed the facility admitted Resident #2 on 10/21/14 with diagnoses which included Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease and Diabetes Mellitus.</p> <p>Review of a Physician's Order, dated 10/23/14, revealed Digoxin 0.125 milligrams (mg) every day. There was no order to obtain the resident pulse prior to the administration of the Digoxin</p>	F 281	<p>of all current resident's physician orders for the past thirty days will be completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers to determine if all were followed timely. Any not followed timely will have physician notification. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing or Unit Managers will observe wound care for all residents with a pressure ulcer to determine if the appropriate treatment was used and if proper infection control standards were used. Any concerns will be immediately corrected with the ordered treatment and education of the Nurse. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing and Unit Managers will complete an audit of all current residents' records to identify any medication that requires monitoring prior to</p>	

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F 281	<p>Continued From page 29</p> <p>and no order to withhold the medication if the resident's pulse was less than sixty (60) beats a minute.</p> <p>Review of the March 2015 Medication Administration Record (MAR) revealed there was no documented evidence staff obtained a pulse before administration of the medication and no documented evidence staff should hold the medication if the pulse was less than 60 beats per minute. Additionally, there was no documented evidence that staff should observe for signs and symptoms of digoxin toxicity.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 03/27/15 at 9:22 AM, revealed she was not aware of the need to take the resident's pulse before administration of digoxin. She stated she was not sure if the medication should be held or not but would notify the physician if the pulse was less than 70. She further stated she was not aware of the signs and symptoms of digoxin toxicity.</p> <p>Interview with the Unit Manager, Registered Nurse (RN) #2 on 03/26/15 at 12:30 PM, revealed it was important to monitor for signs and symptoms of digoxin toxicity and to monitor the pulse before administering the digoxin. He stated the order was incomplete and should have been clarified.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 03/27/15 at 10:02 AM, revealed digoxin was a medication used to regulate the heart rate. She stated she always would take the resident's heart rate before administration and would not administer the medication if the resident's heart rate was less than sixty (60). She stated the</p>	F 281	<p>administration. Any identified as not having this directive in the physician order the order will be immediately obtained to ensure that monitoring and direction is part of the order.</p> <p>3. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing or Unit Managers will re-educate all licensed nurses on the requirement to notify physicians if they are unable to carry out orders timely, and when writing orders for digoxin the order must include monitoring the pulse and if less than 60 to hold the medication, unless the physician has other parameters and if parameters are ordered they must be part of the Medication Administration Record with direction. The Assistant Director of Nursing or Unit managers will audit all physician orders Monday-Friday to ensure all orders with parameters that the order on the MAR</p>		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/27/2015
NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	

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F 281	<p>Continued From page 30</p> <p>resident's order did not say to obtain the pulse nor did it say to withhold the medication for a pulse less than sixty (60); however this was her common practice.</p> <p>Interview with the Director of Nursing (DON), on 03/26/15 at 2:25 PM, revealed she expected the staff to be familiar with medications before administering them. The DON stated the digoxin order should have been clarified and the order was not complete. The DON revealed there should have been an order to obtain the resident's heart rate prior to administering the digoxin and an order to hold the digoxin if the resident's heart rate was less than 60 beats per minute. The DON stated the staff should have been monitoring for signs and symptoms of digoxin toxicity.</p> <p>Interview with the facility's Consultant Pharmacist, on 03/27/15 at 10:40 AM, revealed signs and symptoms of digoxin toxicity could include cardiac arrhythmias, slowing of the heart rate, yellowing vision, slurred speech, and nausea and vomiting. He further stated it would be important to monitor the resident's heart rate before administration and not to administer if the resident's heart rate was less than 60 due the medications effect on slowing the heart rate. He stated that he performed the monthly medication reviews at the facility and he had missed that staff were not obtaining the pulse and if he had realized it, he would have made recommendations.</p> <p>2. Review of the Centers for Disease Control's (CDC's) "Guideline for Hand Hygiene in Health-Care Settings" dated 10/25/02, revealed hands should be decontaminated (removal of dangerous substances or germs through use of</p>	F 281	<p>included the parameters with direction. In addition all current licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager on proper wound care using appropriate infection control practices and following the treatment ordered.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Managers will observe three wound treatments per week for twelve weeks to ensure appropriate infection control standards are met and that the ordered treatment is applied. The Director of Nursing, Assistant Director of Nursing or Unit managers will audit all Medication Administration Records weekly for twelve weeks to ensure all medications were given in an appropriate time frame. The Director of Nursing will audit ten physician orders per week for twelve weeks to ensure that parameters are included in the</p>	

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F 281	<p>Continued From page 31</p> <p>hand washing or an alcohol based sanitizer) after handling wound dressings, when going from a clean area to a dirty area and after removing gloves. Further review revealed hand contamination may occur as a result of small, undetected holes in gloves, as well as during glove removal. Additionally, wearing gloves would not replace the need for hand hygiene.</p> <p>Record review revealed the facility admitted Resident #2 on 10/21/14 with diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, Diabetes Mellitus, and Atrial Fibrillation.</p> <p>Review of a Physician's order, dated 02/19/15, revealed to cleanse Resident #2's left heel with normal saline, apply Biatain Non-Adhesive Foam (absorbant dressing to wick away drainage from the wound bed), and wrap with Kerlix (rolled gauze) every day. Additional review revealed a Physician's Order, dated 02/19/15, to cleanse the right heel with normal saline, apply Santyl (ointment to clear away unhealthy tissue from the wound bed), cover with Biatain Non-Adhesive foam and wrap with Kerlix every day and as needed.</p> <p>Review of a Physician's Order, dated 03/21/15, revealed Bactrim DS (antibiotic) tablet twice a day for seven (7) days for wound culture with Staphylococcus.</p> <p>Observation, on 03/25/15 at 11:15 AM, revealed the Wound Treatment Nurse, Licensed Practical Nurse (LPN) #4 performed catheter care and a head to toe assessment on Resident #2 before performing wound care to his/her left heel. After the catheter care and head to toe body</p>	F 281	<p>order for digoxin or a medication that parameters are given. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>		

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F 281	<p>Continued From page 32</p> <p>assessment and while wearing the same gloves, LPN #4 removed the old dressing to Resident #2's left heel and disposed of the old dressing in a garbage bag. LPN #4 removed her soiled gloves and left the resident's room to obtain a new box of gloves. LPN #4 re-entered Resident #2's room, washed her hands with soap and water and donned clean gloves. LPN #4 cleansed the wound to Resident's #2's left heel with normal saline, applied an abdominal pad (absorbant dressing that is padded to provide protection to large wounds), rather than the physician ordered Biatain Non Adhesive Foam, and wrapped the heel with Kerlix. She removed the soiled gloves; however, did not perform hand hygiene (washing with soap and water or using an alcohol based hand sanitizer) prior to applying the new gloves. LPN #4 then removed the dressing to the resident's right heel and disposed of the soiled dressing in a garbage bag. LPN #4 donned new gloves, again without performing hand hygiene. LPN #4 applied Santyl ointment to the wound bed, covered the wound with gauze rather than the physician ordered Biatain Non Adhesive Foam, and wrapped with a Kerlix. LPN #4 removed the soiled gloves, opened the residents privacy curtain replaced the lid on the Santyl ointment and placed the tube back in the box. She then washed her hands with soap and water and left the resident's room.</p> <p>3. Record review revealed the facility admitted Resident #5 on 08/28/14, with diagnosis to include Alzheimer's Disease, Congestive Heart Failure, Hypertension and Pressure Ulcer, Buttock.</p> <p>Review of a physician's order dated 03/15, revealed cleanse area to right gluteal fold</p>	F 281			

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F 281	<p>Continued From page 33</p> <p>(horizontal crease from inner aspect of buttock to the posterior upper thigh) with Daklins Solution (solution made with chlorine bleach which is a strong antiseptic used to kill most bacteria and viruses) one eighth (1/8) strength, and cover with Biatain Adhesive foam dressing. Further review of the physician's order revealed clean area to right outer foot with normal saline, paint with Betadine (fast acting and broad spectrum antiseptic used to reduce bacteria), cover with non-adhesive Biatain foam, wrap in Kerlix to secure.</p> <p>Observation, on 03/25/15 at 10:45 AM, revealed the Wound Treatment Nurse, Licensed Practical Nurse (LPN) #4 performed wound care. Further observation revealed LPN #4 removed the dressing to the resident's right heel wound ( Suspected Deep Tissue Injury) and placed the soiled dressing in a garbage bag. The LPN #4 measured the wound 0.8 centimeters (cm) length and 0.7 cm width. LPN #4 cleansed the wound with normal saline, then painted the wound bed with Betadine and placed a gauze pad rather than the physician ordered Biatain non adhesive foam dressing and wrapped the heel with Kerlix. LPN #4 removed the soiled gloves and donned clean gloves. LPN #4 left Resident #5's room to obtain a disposable wound measuring ruler and returned to Resident #5's room. LPN #4 was not observed to have performed hand hygiene before she left the resident's room or after she returned. LPN #4 donned clean gloves and removed the soiled dressing to Resident #5's gluteal fold (horizontal crease from inner aspect of buttock to the posterior upper thigh) and disposed of in a garbage bag. LPN #4 removed soiled gloves and donned new clean gloves. LPN #4 cleansed the wound to Resident #5 gluteal fold with normal</p>	F 281			

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F 281	<p>Continued From page 34</p> <p>saline rather than the physician ordered Dakins one eighth strength (1/8), and removed the soiled gloves. Without performing hand hygiene, LPN #4 donned clean gloves. LPN #4 placed the Biatain adhesive foam bordered dressing and removed the soiled gloves. Without performing hand hygiene LPN #4 donned clean gloves and performed a head to toe skin assessment. She then removed gloves and performed hand hygiene.</p> <p>Interview with LPN #4, on 03/27/15 at 8:00 AM, revealed she should have sanitized her hands in between each glove change. She stated she normally did however does not every time she changes gloves. She stated it was important to sanitize her hands between each glove change due to the potential for contamination and to help control infections.</p> <p>Post Survey Interview with LPN #4 on 04/10/15 at 10:00 AM, revealed the facility was out of the physician ordered Dakins solution, therefore, she substituted the normal saline to cleanse the wound. She stated the difference in the normal saline and the Dakins solution was the normal saline was like water and the Dakins solution contained bleach and was an antiseptic. Further interview revealed the facility was also out of the physician ordered Biatain Non Adhesive Foam; therefore, she used the abdominal pad and gauze. She stated she should have notified the physician and obtained new orders for wound care, however, she did not.</p> <p>Interview with the Unit Manager, Registered Nurse #2, on 03/26/15 at 12:30 PM, revealed the facility's policy stated and his expectation would be for staff to perform hand hygiene with each</p>	F 281			

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F 281	<p>Continued From page 35</p> <p>glove change per the facility's policy and procedure.</p> <p>Interview with the Director of Nursing (DON) on 03/26/15 at 12:40 PM, revealed it was the facility's policy and procedure and her expectation to perform hand hygiene with each glove change.</p> <p>4. Review of the Kentucky Board of Nursing AOS #14 Patient Care Orders, last revised 10/2010, revealed nurses are held responsible and accountable for their decisions regarding the receipt and implementation of patient care orders and the administration of medication and treatment as prescribed by the physician or advanced practice registered nurse. Further review revealed licensed nurses should administer medication at the prescribed dosage, route and frequency.</p> <p>Review of the facility policy, Medication Administration, undated, revealed the facility strives to provide safe administration of all medications according to the six (6) rights - medication, dose, dosage form, route, resident and time.</p> <p>Record review revealed the facility admitted Resident #9 on 11/20/13 with diagnoses which included Dementia, Hypertension, Anxiety and Conjunctivitis.</p> <p>Review of the Physician's Order Sheet, dated 05/04/15 at 2:25 PM, revealed a telephone order for Decadron four (4) mg IM to be administered "now"; however, review of the March 2015 MAR revealed the now dose of Decadron was not administered until the following day, on 03/05/15 at 6:30 PM.</p>	F 281		
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F 281	<p>Continued From page 36</p> <p>Post survey interview with Licensed Practical Nurse (LPN) #4, on 04/10/15 at 9:32 AM, revealed she had been notified by other staff that Resident #9 had a rash. LPN #4 stated when she went to assess the resident, the resident was digging and scratching at her skin. She revealed she then phoned the physician and received new orders to include a now dose of Decadron 4 mg IM. LPN #4 revealed after checking the Emergency Drug Kit (EDK) and not finding the medication in the kit, she faxed the order to the pharmacy and followed up with a phone call. She stated she spoke with a female at the pharmacy and notified the female that she needed the Decadron stat. LPN #4 stated the female asked if it could be delivered with the nine (9) PM medications and she told her no that it was needed stat. LPN #4 revealed the medication had not arrived by the time her shift ended at seven 7:00 PM so she reported that to the oncoming staff. LPN #4 stated she was not aware the medication was not delivered until the next day (03/05/15) until approximately a week later. The LPN stated she did not notify the physician before she left that the medication had not been received. She stated, "I should have called the pharmacy before I left".</p> <p>Interview with the Director of Nursing (DON), on 03/28/15 at 11:15 AM, revealed staff was expected to follow through with physician orders and the medication should have been administered in a timely manner according to the order from the physician.</p>	F 281		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283	<p>F283 1. A discharge summary that includes a recapitulation of the</p>	5/11/15

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F 283	<p>Continued From page 37</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a discharge summary that included a recapitulation of the resident's stay was completed for one (1) of sixteen (16) sampled residents (Resident #15). Resident #15 was discharged on 11/03/14; however, there was no evidence a discharge summary was completed.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 03/27/15 at 2:30 PM, revealed there was no policy to address the completion of a recapitulation of stay for a discharged resident.</p> <p>Record review revealed the facility admitted Resident #15 on 11/03/14 with diagnoses which included Hypertension, Osteoporosis, Scoliosis, Chronic Obstructive Pulmonary Disease, and Glaucoma.</p> <p>Review of Physician's Order, dated 11/28/14, revealed Resident #15 was to be discharged home with home health services.</p> <p>Review of a Discharge Instruction Form, dated</p>	F 283	<p>resident's stay and status on discharge will be completed for resident # 15 by 05/10/215 by each department to include. Nursing, Social Services, Activities and Nutrition Services.</p> <p>2. An audit of all planned discharges for all residents discharged in the past thirty days will be completed by Medical Records and the Discharge Summary will be completed by Nursing, Social Services, Activities and Nutrition Services by 05/10/2015. Any identified as not having a summary and recapitulation of stay will be completed by 05/10/15.</p> <p>3. By 05/10/2015 the Director of Nursing will educate the Social Services Director, Activities and Nutrition Services manager on the requirement to complete a recapitulation of the resident's stay and status at discharge for any planned discharge.</p> <p>4. The Director of Nursing will audit three planned discharges if available</p>	

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F 283	Continued From page 38 11/28/14, revealed there was no documentation of a recapitulation of the resident's stay and status on discharge.  Further interview with the Director of Nursing (DON), on 03/27/15 at 2:30 PM, revealed a recapitulation summary of the resident's stay in the facility and the resident's current functional status should have been documented on the discharge instruction form. The DON stated the Interdisciplinary Team (IDT) members (Social Services, Captivity, Therapy, Dietary, etc.) should have documented related to the resident's stay. The DON revealed to her knowledge the discharge instruction form was the only form used.	F 283	monthly for three months to ensure that a recapitulation of stay was completed. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.	
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: Based on interview, record review and review of the facility's policy and procedures, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of sixteen (16) sampled residents (Resident #9). Resident #9	F 309	F309 1. The Decadron for resident # 9 was administered on 03/05/2015 by a staff nurse. 2. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing or Unit Manager will audit all physician	5/11/15

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F 309	<p>Continued From page 39</p> <p>was ordered Decadron Intramuscular IM "Now"; however, the medication was not administered until the next day approximately twenty-six hours later.</p> <p>The findings include:</p> <p>Review of the facility policy, Medication Administration, undated, revealed the facility strives to provide safe administration of all medications according to the six (6) rights-medication, dose, dosage form, route, resident and time.</p> <p>Record review revealed the facility admitted Resident #9 on 11/20/13 with diagnoses to include Anxiety, Hypothyroidism and Hypertension. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 02/19/15, revealed the facility assessed Resident #9's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of "00" which indicated the resident was not interviewable.</p> <p>Review of Nurses Notes, dated 03/04/15 at 5:06 PM, revealed the nurse phoned the physician related to the development of a rash to Resident #9's upper chest, arms and legs.</p> <p>Review of a Comprehensive Physician Order Sheet, dated 03/04/15 at 2:25 PM, revealed a telephone order for Decadron four (4) mg IM now</p> <p>Review of the Comprehensive Care Plan, dated 03/04/15, revealed the care plan was updated to include the development of the rash. The Care Plan was also updated on 03/24/15 regarding the referral to the Dermatologist.</p>	F 309	<p>orders for the past thirty days to determine if physician orders were carried out appropriately per physician order. Any identified as not will have physician notification with further direction.</p> <p>3. By 05/10/2015 all current licensed nurses will have re-education on notification of the physician if they are unable to carry out the physician orders timely.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all Medication Administration Records weekly for twelve weeks to ensure medications are administered timely per physician orders and if not that the physician was notified for further direction. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene</p>		

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F 309	Continued From page 40  Review of the March 2015 Medication Administration Record revealed the resident was administered Decadron 4 mg. IM on 03/05/15 at 6:30 PM approximately twenty-six (26) hours after the order was received to administer "now".  Review of Nurses Notes, dated 03/24/15 at 4:12 PM, revealed the physician was notified the resident continued to have a rash. An order was received to make an appointment for the resident with the dermatologist.  Review of a Telephone Order, dated 03/24/15 at 3:25 PM, revealed an order to refer the resident to a local Dermatologist related to the rash.  Observation of Resident #9's skin with the Unit Manager, on 03/26/15 at 9:20 AM, revealed a red rash was noted to resident's trunk and arms. The resident was not observed scratching the affected areas.  Interview with Unit Manager, Registered Nurse (RN) #2, on 03/26/15 at 2:00 PM, revealed the Decadron wasn't received from the pharmacy on the day it was ordered and the error was not discovered until the following day. The Decadron was administered on 03/05/15 at 6:30 PM by Registered Nurse (RN) #2.	F 309	to review and make further recommendations The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312-  1. The nails for resident # 3 and unsampled resident B were cleaned and trimmed by the MDS	5/11/15

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F 312	<p>Continued From page 41</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents who were unable to carry out Activities of Daily Living (ADL's), received the necessary services to maintain good grooming and personal hygiene related to providing nail care for two (2) of sixteen (16) sampled residents (Resident #3) and one (1) unsampled resident (Unsampled Resident B).</p> <p>The findings include:</p> <p>Interview with Director of Nursing (DON), on 3/26/15 at 1:00 PM, revealed the facility did not have an exact policy on specifics for frequency of nail care and the facility used the Mosby's Book for the Certified Nurse Aide (CNA) tasks. The facility provided a copy of nail and foot care procedures, out of "Mosby's textbook for Long Term Care Nursing Assistants 5th edition" but not a policy and procedure on when or how often nail cares were to be performed or how often nails were checked for need of nail care.</p> <p>1. Record review revealed the facility admitted Unsampled Resident B on 01/27/15 with diagnoses which included Pleural Effusion, Encephalopathy, Hypertension, Esophageal Reflux, Dementia NOS, Hyperlipidemia, Thyroid Disorder, Open wound of buttocks, and Deficient Anemia. Review of the Admission Minimum Data Set (MDS) assessment, dated 02/03/15, revealed the facility assessed Unsampled Resident B's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) of "4" which</p>	F 312	<p>Assistant on 03/24/2015 The Director of Nursing observed that the nails for resident # 3 and unsampled resident B were clean and trimmed on 04/15/2015.</p> <p>2. On 04/17/2015 the Assistant Director of Nursing, Unit Managers, MDS Coordinator, MDS assistant completed an audit of all resident's finger nails to identify any that were unclean or nails that needed trimming. Any identified had their nails cleaned and trimmed immediately.</p> <p>3. All current nursing assistants will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Managers on completing nail care on shower days. The Department Heads will conduct rounds five times per week to identify any concerns with nail care</p> <p>4. The Administrator will audit 10 residents per week for twelve weeks to determine if department heads are identifying concerns with nail care. The results of these</p>	
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F 312	<p>Continued From page 42</p> <p>indicated the resident was not interviewable. Further review of this MDS, revealed the facility assessed the resident as requiring extensive assistance with two (2) persons physical assist for personal hygiene cares.</p> <p>Review of the Comprehensive Care Plan for Self Care Deficit, dated 01/27/15, revealed an intervention to setup, cue and assist resident as needed with activities of daily living (ADL).</p> <p>Observation of Unsampled Resident B, on 03/24/15 at 1:55 PM, revealed he/she had long and dirty finger nails to all fingers and thumbs of both hands.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 03/27/15 at 7:50 AM, revealed expectations for nail care were for nails to be trimmed, cleaned and or filed as needed because residents eat with their hands. She further stated nail care was supposed to have been done on bath days and whenever necessary.</p> <p>Interview with CNA #2, on 3/27/15 at 7:55 AM, revealed expectations for nail care was for nail care to have been checked daily for need and done on bath days.</p> <p>Interview with Unit Manager Licensed Practical Nurse (LPN) #1, on 03/24/15 at 2:00 PM, revealed nail care should have been done with all showers and bed baths. She stated the charge nurses and unit managers were to make sure that nail care was completed.</p> <p>Interview with Director of Nursing (DON), on 3/26/15 at 1:00 PM, revealed she expected for routine nail care to be done on all residents. The</p>	F 312	<p>audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>		

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F 312	<p>Continued From page 43</p> <p>DON stated all nurses, unit managers, and administrative nurses were responsible for ensuring nail care was being done. The DON revealed nail care was very important and should have been done routinely without exception unless there had been a contraindication or physician's order not to perform nail care.</p> <p>2. Record review revealed the facility admitted Resident #3 on 04/15/09, with diagnoses which included Hypertension, Anxiety, Alzheimer's Disease, and Rash. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/05/15, revealed the facility identified the resident's cognitive status as severely impaired with a Brief Interview of Mental Status score of "99" which indicated the resident was not interviewable.</p> <p>Observation of Resident #3, on 03/24/15 at 9:35 AM, revealed the resident was in a geri-chair reclined, with the chair alarm visible on back of chair, physically leaning to the left with pillow under left side. There was facial hair visible to the chin and cheek area and his/her finger nails were long with a visible yellow substance under his/her nails.</p> <p>Observation of Resident #3, on 03/25/15 at 7:35 AM, revealed the was resident in the geri-chair in the main dining room at the dining table. Further observation revealed the resident's nails remained long with visible substance under nails.</p> <p>Interview with Certified Nursing Assistant (CNA) # 4, on 03/26/15 at 3:35 PM, revealed she gave the resident a shower last night on 03/25/15 after the supper meal. She continued to reveal she did not trim the residents nails with his/her bath last</p>	F 312			

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F 312	<p>Continued From page 44</p> <p>night. She was unable to state the reason she did not trim the residents nails.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 03/27/15 at 7:50 AM, revealed she revealed she had not seen anyone clip his/her nails and understands why that could be a problem for the resident related to infection control issues and appearance.</p> <p>Interview with Registered Nurse (RN) #5, on 03/27/15 at 11:30 AM, revealed she stated she had not clipped the resident's nails and continued to state "I need to keep on top of that". She was not aware when the last time the resident's nails had been clipped.</p> <p>Interview with RN #4, on 03/26/15 at 8:45 AM, revealed there was not a specific site on the resident's Treatment Flow Sheet for nail care. She stated when the staff conduct the resident's scheduled body audit the nails should be monitored and documented on the skin assessment flow sheet. RN #1 revealed she realized the importance of nail care due to the resident's frequent scratching as well as his/her appearance. She further revealed the Unit Manager was responsible to do audits of the Medication Administration Records (MAR's) and the Treatment Administration Records (TAR'S) as well as skin assessments to ensure care is being provided.</p> <p>Interview with RN #2 Unit Manager, on 03/26/15 at 9:00 AM, revealed he was not aware the residents finger nails needed trimming. He stated nail care should be addressed with bathing and skin assessments weekly and the care of nails and shaving should be completed with baths. He</p>	F 312		

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F 312	Continued From page 45 further revealed he expected the staff to complete nail care and shaving during the bath or for staff to notify their charge nurse if they were unable to complete the assignment.  Interview with Housekeeping Supervisor, on 03/26/15 at 10:05 AM, revealed the facility has a system in place where each resident is assigned a Caring Partner to go into the resident's room each morning and look at the resident's environment as well as the resident to make sure the resident's care needs are being met.  Interview with Director of Nursing (DON), on 3/26/15 at 12:40 PM, revealed the Caring Partners are administrative staff that are assigned to a group of residents and they are expected to make rounds on the residents each morning before morning meeting. She stated they are expected to check the resident's room for safety issues, dignity issues, environmental concerns, cleanliness of the resident, and grooming needs of the resident. She further stated if the caring partner was a clinical staff member she would have expected them to have clipped the residents nails or performed whatever service that was needed at the time. She continued to reveal the residents nails should be cut routinely with his bath and anytime they are found to need cutting. She stated every staff member is responsible that observes the resident daily to see that his needs are met. She further revealed the nurses should have observed it in their weekly skin assessment and trimmed then.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a	F 314	F314 1. An observation of wound treatments to resident # 2 and #5 by the director of nursing on 04/16/2015 noted that treatments were applied per	5/11/15	

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F 314	<p>Continued From page 46</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's copy of the Centers for Disease Control guideline for hand hygiene it was determined the facility failed to ensure residents having a pressure sore were provided the necessary treatment and services to promote healing and prevent infection for two (2) of sixteen (16) sampled residents (Resident #2 and Resident #5) related to improper wound care.</p> <p>The findings include:</p> <p>Review of the Centers for Disease Control's (CDC's) "Guideline for Hand Hygiene in Health-Care Settings" dated 10/25/02, revealed hands should be decontaminated (removal of dangerous substances or germs through use of hand washing or an alcohol based sanitizer) after handling wound dressings, when going from a clean area to a dirty area and after removing gloves. Further review revealed hand contamination may occur as a result of small, undetected holes in gloves, as well as during glove removal. Additionally, wearing gloves would not replace the need for hand hygiene.</p> <p>1. Record review revealed the facility admitted</p>	F 314	<p>physician order and appropriate infection control standards were used. The Director of Nursing on 04/20/15 provided one on one re-education with LPN # 4 related to hand washing and infection control practices with wound care as well as following physician orders for treatments.</p> <p>2. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing or Unit Managers will observe wound care for all current residents with a pressure ulcer to determine if the appropriate treatment was used and if proper infection control standards were used. Any concerns will be immediately corrected with the ordered treatment and education of the Nurse.</p> <p>3. By 05/10/2015 the Director of Nursing, Assistant Director of Nursing or Unit Managers will re-educate all licensed nurses on proper wound care using appropriate infection</p>	

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F 314	<p>Continued From page 47</p> <p>Resident #2 on 10/21/14 with diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, Diabetes Mellitus, and Atrial Fibrillation.</p> <p>Review of the Comprehensive Care Plan, dated 11/04/14, revealed Resident #2 was at risk for impaired skin integrity due to unstageable wound to his/her heels. Further review revealed interventions to provide treatment as ordered.</p> <p>Review of a Physician's Order, dated 02/19/15, revealed to cleanse Resident #2's left heel with normal saline, apply Biatain Non-Adhesive Foam (absorbant dressing to wick away drainage from the wound bed), and wrap with Kerlix (rolled gauze) every day. Additional review revealed a Physician's Order, dated 02/19/15, to cleanse the right heel with normal saline, apply Santyl (ointment to clear away unhealthy tissue from the wound bed), cover with Biatain Non-Adhesive foam and wrap with Kerlix every day and as needed.</p> <p>Review of a Physician's Order, dated 03/21/15, revealed Bactrim DS (antibiotic) tablet twice a day for seven (7) days for wound culture with Staphylococcus.</p> <p>Observation, on 03/25/15 at 11:15 AM, revealed the Wound Treatment Nurse, Licensed Practical Nurse (LPN) #4 performed catheter care and a head to toe assessment on Resident #2 before performing wound care to his/her left heel. After the catheter care and head to toe body assessment and while wearing the same gloves, LPN #4 removed the old dressing to Resident #2's left heel and disposed of the old dressing in a garbage bag. LPN #4 removed her soiled</p>	F 314	<p>control practices and following the treatment ordered.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Managers will observe three wound treatments per week for twelve weeks to ensure appropriate infection control standards are met and that the ordered treatment is applied. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5.</p>	

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F 314	<p>Continued From page 48</p> <p>gloves and left the resident's room to obtain a new box of gloves. LPN #4 re-entered Resident #2's room, washed her hands with soap and water and donned clean gloves. LPN #4 cleansed the wound to Resident's #2's left heel with normal saline, applied an abdominal pad (absorbant dressing that is padded to provide protection to large wounds), rather than the physician ordered Biatain Non Adhesive Foam, and wrapped the heel with Kerlix. She removed the soiled gloves; however, did not perform hand hygiene (washing with soap and water or using an alcohol based hand sanitizer) prior to applying the new gloves. LPN #4 then removed the dressing to the resident's right heel and disposed of the soiled dressing in a garbage bag. LPN #4 donned new gloves, again without performing hand hygiene. LPN #4 applied Santyl ointment to the wound bed, covered the wound with gauze rather than the physician ordered Biatain Non Adhesive Foam, and wrapped with a Kerlix. LPN #4 removed the soiled gloves, opened the residents privacy curtain replaced the lid on the Santyl ointment and placed the tube back in the box. She then washed her hands with soap and water and left the resident's room.</p> <p>2. Record review revealed the facility admitted Resident #5 on 08/28/14, with diagnosis to include Alzheimer's Disease, Congestive Heart Failure, Hypertension and Pressure Ulcer, Buttock.</p> <p>Review of the Comprehensive Care Plan dated 11/19/14, revealed Resident #5 was as risk for impaired skin integrity due to actual pressure ulcers. Further review revealed interventions for treatment as ordered.</p>	F 314		
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F 314	<p>Continued From page 49</p> <p>Review of a Physician's Order, dated 03/15/15, revealed to cleanse area to right gluteal fold (horizontal crease from inner aspect of buttock to the posterior upper thigh) with Dakins Solution (solution made with chlorine bleach which is a strong antiseptic used to kill most bacteria and viruses) one eighth (1/8) strength, and cover with Biatain Adhesive foam dressing. Further review of the physician's order revealed clean area to right outer foot with normal saline, paint with Betadine (fast acting and broad spectrum antiseptic used to reduce bacteria), cover with non-adhesive Biatain foam, wrap in Kerlix to secure.</p> <p>Observation, on 03/25/15 at 10:45 AM, revealed the Wound Treatment Nurse, Licensed Practical Nurse (LPN) #4 performed wound care. Further observation revealed LPN #4 removed the dressing to the resident's right heel wound ( Suspected Deep Tissue Injury) and placed the soiled dressing in a garbage bag. The LPN #4 measured the wound 0.8 centimeters (cm) length and 0.7 cm width. LPN #4 cleansed the wound with normal saline, then painted the wound bed with Betadine and placed a gauze pad rather than the physician ordered Biatain non adhesive foam dressing and wrapped the heel with Kerlix. LPN #4 removed the soiled gloves and donned clean gloves. LPN #4 left Resident #5's room to obtain a disposable wound measuring ruler and returned to Resident #5's room. LPN #4 was not observed to have performed hand hygiene before she left the resident's room or after she returned. LPN #4 donned clean gloves and removed the soiled dressing to Resident #5's gluteal fold (horizontal crease from inner aspect of buttock to the posterior upper thigh) and disposed of in a garbage bag. LPN #4 removed soiled gloves and</p>	F 314			

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F 314	<p>Continued From page 50</p> <p>donned new clean gloves. LPN #4 cleansed the wound to Resident #5 gluteal fold with normal saline rather than the physician ordered Dakins one eighth strength (1/8), and removed the soiled gloves. Without performing hand hygiene, LPN #4 donned clean gloves. LPN #4 placed the Biatain adhesive foam bordered dressing and removed the soiled gloves. Without performing hand hygiene LPN #4 donned clean gloves and performed a head to toe skin assessment. She then removed gloves and performed hand hygiene.</p> <p>Interview with LPN #4, on 03/27/15 at 8:00 AM, revealed she should have sanitized her hands in between each glove change. She stated she normally did however does not every time she changes gloves. She stated it was important to sanitize her hands between each glove change due to the potential for contamination and to help control infections.</p> <p>Post Survey Interview with LPN #4 on 04/10/15 at 10:00 AM, revealed the facility was out of the physician ordered Dakins solution, therefore, she substituted the normal saline to cleanse the wound. She stated the difference in the normal saline and the Dakins solution was the normal saline was like water and the Dakins solution contained bleach and was an antiseptic. Further interview revealed the facility was also out of the physician ordered Biatain Non Adhesive Foam; therefore, she used the abdominal pad and gauze. She stated she should have notified the physician and obtained new orders for wound care, however, she did not.</p> <p>Interview with the Unit Manager, Registered Nurse #2, on 03/26/15 at 12:30 PM, revealed the</p>	F 314			

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F 314	Continued From page 51 facility's policy stated and his expectation would be for staff to perform hand hygiene with each glove change per the facility's policy and procedure.	F 314			
F 323 SS=E	Interview with the Director of Nursing (DON) on 03/26/15 at 12:40 PM, revealed it was the facility's policy and procedure and her expectation to perform hand hygiene with each glove change. <b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide supervision and assistive devices for one (1) of sixteen (16) sampled residents (Residents #2). In addition, the facility failed to ensure the residents environment remains free of accident hazards as is possible. A treatment medication was observed in a resident's room unsupervised and portable oxygen tanks were being filled with the door open and no personal protective equipment being utilized.  Interview with the Director of Nursing (DON), on 3/26/15 at 12:40 PM, revealed there are seven	F 323	F323 1. By 05/10/2015 the Director of Nursing will review all falls for the past sixty days for resident # 2 to ensure all interventions are appropriate and in place. On 03/24/2015 the treatment supplies from room four were removed by Unit Manager. On 04/16/2015 the Director of Nursing observed CNA # 3 and # 10 to be filling portable liquid oxygen tanks with the door closed and proper protective equipment in use. On 03/25/2015 the oxygen fill room was reorganized by the Director of Nursing and	5/11/15	

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F 323	<p>Continued From page 52</p> <p>(7) residents in the facility that are considered elopement risk and wander throughout the facility at times.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Fall Assessment/Intervention Process", dated 09/2013, revealed the purpose of the policy and procedure was for all residents on any admission, re-admission, and at least quarterly to be assessed for fall risk and appropriate interventions should be initiated immediately to reduce the risk of injuries with falls. Any resident who experiences a fall will have a CAA fall worksheet completed to assure all identified risk factors are taken into consideration according to F323, by investigations of falls and incidents. The facility must ensure that (a) the resident environment remains as free from accident hazards as is possible; and (b) each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1. Record review revealed the facility admitted Resident #2 on 10/21/14 with diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, Diabetes Mellitus, and Atrial Fibrillation.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 01/21/15, revealed the facility had assessed Resident #2's cognition as moderately impaired, with a Brief Interview for Mental Status (BIMS) score of nine (9), indicating the resident was interviewable. Further review revealed the facility had assessed Resident #2 to require extensive assistance with Activities of Daily Living (ADLs').</p>	F 323	<p>the Assistant Director of Nursing to make more room for staff to fill the tanks. On 04/16/2015 the Assistant Director Re-educated the CNA # 3 and # 10 on the proper procedure to fill the tanks.</p> <p>2. By 05/10/15 the Director of Nursing will review all falls for the past 60 days to ensure all interventions are in place and on the care plan. On 04/15/2015 an observation of all current resident's rooms was completed by Director of Nursing to identify any hazardous supplies or chemicals. Any identified will be immediately removed. On 04/15/2015 and 04/16/2015 the Director of Nursing observed staff filling portable liquid oxygen tanks with the door closed and staff donning personal protective equipment.</p> <p>3. By 05/10/15 all current nursing assistants will be re-educated on the proper procedure to transfill liquid oxygen tanks including closing the door and wearing</p>	

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F 323	Continued From page 53  Review of the Comprehensive Care Plan, dated 10/23/14, revealed Resident #2 was assessed to be at risk for injury related to falls as evidenced by the resident's history of frequent falls with interventions for a bed alarm and a low bed.  Review of the facility's Resident Incident Report, dated 03/01/15, revealed Resident #2 had a non-witnessed fall on 03/01/15 at 1:21 AM. Further review revealed Resident #2's bed alarm was sounding, and he/she was calling for help. Resident #2 was found face down on the floor at the bedside. Additional review revealed Resident #2 was bleeding above his/her left eye and a gauze and steri-strips were applied.  Interview with the Director of Nursing (DON), on 03/28/15 at 2:25 PM, revealed Resident #2 had a history of frequent falls. The DON stated when Resident #2 fell on 03/01/15, there should have been non-skid strips on the floor beside his/her bed. The DON revealed when Resident #2 was admitted to the facility he/she was placed in the bed by the window [bed (2)]. She stated Resident #2 was moved to the first bed on 02/21/15; however, the non-skid strips were not placed to the floor beside bed 1 when the resident was moved. She further stated, she observed the resident's room on 03/25/15 and noted the non-skid strip was not in place. She stated she reviewed the care plan and found the intervention had been removed. She stated the non-skid strips should have been placed beside Resident #2's new bed and should not have been removed from the care plan. She stated when she realized the non-skid strips were not in place she immediately had them replaced. She stated she did not know who removed them from the care	F 323	PPE. By 04/25/15 the Regional Quality Manager will educate the IDT team on updating and reviewing fall care plans in the daily clinical meeting and weekly in the weekly falls committee. By 05/10/15 all current nursing assistants and licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, or Unit Managers on the requirement to not leave hazardous chemicals at bed side.  4. The Director of Nursing will review all falls weekly for twelve weeks to ensure the interventions are placed on the care plan and interventions are in place. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe trans filling of liquid oxygen three times per week for twelve weeks. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all resident	

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F 323	<p>Continued From page 54 plan but the intervention should not have been removed.</p> <p>Observations on 03/24/15 at 8:50 AM, of Resident #2's room revealed Resident #2 had a low bed. Further observation revealed there was non skid-strips to the bed by the window; however, there was no non skid strips to the bed by the door.</p> <p>Further review of the Falls care plan, dated 10/23/14, revealed no documented evidence for an intervention for non-skid strips to bilateral bedside.</p> <p>2. Review of a facility's Clinical Competency Validation for Filling Liquid Portables, not dated revealed when filling liquid portable oxygen tanks staff should enter the oxygen fill room and close the door. Further review revealed staff should then don goggles and gloves.</p> <p>An observation on 03/25/15 at 10:15 AM, revealed Certified Nurse Aide (CNA) #3 and CNA #10 filling portable liquid oxygen tanks in the oxygen fill room with the door open. Further review revealed CNA #3 and CNA #10 were not wearing the required goggles and gloves.</p> <p>Interview with CNA #3, on 03/27/15 at 9:10 AM, revealed she was aware of the facility's policy to have the door to the oxygen fill room shut when filling portable liquid oxygen tanks. She stated this was a safety measure in case the tank were to burst it would stay confined. She further stated she was orienting CNA #10 and there was not enough room for two (2) of them in the room; therefore, she left the door open so CNA could observe. She further stated she was aware she</p>	F 323	<p>rooms three times per week for twelve weeks to ensure there are no unsecured hazardous chemicals. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>		

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F 323	<p>Continued From page 55</p> <p>was supposed to wear goggles and gloves but stated she had not put them on because she just didn't think about it.</p> <p>Interview with CNA #10 on 03/27/15 at 9:12 AM, revealed this was her first day working on the floor at the facility. She further stated she had never filled oxygen tanks before.</p> <p>Interview with the Director of Nursing, (DON) on 03/25/15 at 10:20 AM, revealed when filling oxygen tanks the door to the oxygen fill room should be closed. She further stated it was her expectation staff should utilize the appropriate personal protective equipment when filling the portable liquid oxygen tanks. She stated this was important to decrease the risk of accidents and hazards as there was a risk the tanks could burst.</p> <p>3. Review of the facility's policy titled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, (dated 12/01/07, last updated 1/01/03), revealed Applicability : This policy sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. General Storage Procedures: 3.1 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.</p> <p>Initial tour of the facility, on 03/24/15 at 9:00 AM, revealed upon entering Resident #4's room multiple packages of gauze supplies were visible on the counter in the resident room. Medication used to complete the wound care was also on the counter. Further investigation revealed a bottle of</p>	F 323			

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F 323	Continued From page 56 SAF cleanser and a container of Dermal Wound cleanser. Review of the wound cleaner label revealed for external use only, avoid contact with eyes.  Interview with Resident #4 (review of MDS assessment revealed BIMS score of 15 which indicated interviewable), on 03/24/15 at 9:00 AM, revealed the nurses left that in his/her room. He/She stated staff do his/her treatments twice daily or when ever they need changing. He/she revealed there were residents that wander into the room at times, but none recently.  Interview with Wound Care Nurse, on 03/27/15 at 7:30 AM, revealed she did not leave the treatment supplies in the residents room. She stated she thought it was the eleven to seven (11-7) shift that was responsible for that.  Interview with the Director of Nursing (DON), on 3/26/15 at 12:40 PM, revealed it was not acceptable to leave treatments or any supplies in the resident's rooms. She revealed that her expectations were for the staff to remove all treatment materials and cleaning supplies from the residents room and they should be treated as any other medication and that no resident in the facility is care planned to self administer medication. She further revealed she realized the importance of removing all treatment supplies related to safety hazards due to the seven residents that wander through out the facility.	F 323			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times	F 368	F368  1. On 04/16/2015 the Dietary Services observed HS snack pass	5/11/15	

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F 368	<p>Continued From page 57</p> <p>comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview it was determined the facility failed to ensure snacks were offered to every resident at bedtime daily.</p> <p>The findings include:</p> <p>Interview with the Registered Dietitian (RD), on 04/07/15 at 9:40 AM, revealed there was no written policy to her knowledge related to offering bedtime snacks to all residents.</p> <p>During a group interview with five (5) residents, (with a Brief Interview of Mental Status (BIMS) scores between eight (8) and fifteen (15) which indicated they were interviewable), on 03/24/15 at 2:00 PM, revealed only certain residents get a bedtime snack every night and they would like a snack as well.</p> <p>Interview with Resident #4, on 03/27/15 at 10:45</p>	F 368	<p>and noted that snacks were available and staff were offering snacks to all residents.</p> <p>2. On 04/20/2015 the Dietary Services observed HS snack pass and noted that snacks were available and staff were offering snacks to all residents.</p> <p>3. On 04/15/2015 The Director of Nursing re-educated the Dietary Service Manager on the requirement to offer snacks to all residents at HS and to maintain an adequate supply of snacks. By 05/10/15 all current nursing assistants will be re-educated to offer HS snacks to all residents this education will be provided by the Administrator, Dietary Service Manager, Director of Nursing, and Assistant Director of Nursing or Unit Managers.</p> <p>4. The Dietary Service Manager, Administrator, Director of Nursing assistant Director of Nursing, Social Service Director of MDs Nurse will observe snack pass</p>		

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F 368	<p>Continued From page 58</p> <p>AM, revealed at times the facility runs out of snacks and he has to ask for a snack in order to receive one and if he/she doesn't ask early enough he/she does not receive one.</p> <p>Interview with Certified Nursing Assistant (CNA) #7 (who worked 7:00 AM to 3:00 PM), on 03/27/15 at 11:00 AM, revealed the residents who are diabetics and are on the nutritional at risk (NAR) program have snacks at night labeled with their names on them. She stated the other residents have to ask for snacks and the request for a snack has to be placed before the kitchen closes.</p> <p>Interview with CNA #9, on 04/09/15 at 12:15 PM, revealed she worked the 3:00 PM to 11:00 PM shift and works both of the halls. She stated snacks are programmed in the Accu-Nurse headset (system used for documenting meals and snack intake) for the diabetics and residents on the nutritional at risk program. She stated these residents are given snacks regardless of whether they eat them or not and every other resident in the building is offered a snack at approximately 7:00 PM.</p> <p>Interview with the Dietary Manager, on 03/25/15 at 9:05 AM, revealed snacks are offered to every resident at bedtime daily; however, residents with a diagnosis of diabetes or residents that are nutritionally at risk (NAR) are given a snack every night at bedtime. Further interview, on 03/27/15 at 10:50 AM, revealed she was unaware of the need to offer every resident a snack at bedtime.</p> <p>Further interview with the Registered Dietitian (RD), on 04/07/15 at 9:40 AM, revealed every resident should be offered a snack daily at</p>	F 368	<p>two times per week for four weeks then weekly for eight weeks to ensure there is an adequate supply of snacks and snacks are offered to all resident. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p>		

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F 368	Continued From page 59 bedtime and residents with a diagnosis of diabetes and ones on the NAR program have snacks that are scheduled with their names and dates on them.  Interview with the Assistant Director of Nursing (ADON), on 03/25/15 at 9:00 AM, revealed the NAR residents and diabetics are the only residents to receive a snack at bedtime and the other residents have to ask for them.  Interview with the Director of Nursing, on 03/26/15 at 3.10 PM, revealed all residents should be offered a snack daily at bedtime and the residents with diabetes and ones on the NAR program are given a snack at bedtime daily.	F 368			
F 371 SS=E	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 review of the facility's policy and procedure, it was determined the facility failed to ensure food was stored and prepared under sanitary conditions related to food in the refrigerator opened and not	F 371	F371  1. The identified opened and undated food was thrown away on March 24, 2015 by the dietary services manager. The chocolate milk was removed from the refrigerator and thrown away on March 24, 2015 by the Dietary services Manager. The dietary manager put on a hairnet immediately on March 24, 2015. The meat slicer was taken out of operation on 03/24/15 until a replacement blade to be obtained.	5/11/15	

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F 371	<p>Continued From page 80</p> <p>dated when it was opened, an employee's personal quart of chocolate milk open and stored in the kitchen refrigerator and the Dietary Manager observed in the kitchen without a hair net.</p> <p>Review of the Census and Condition report, dated 03/24/15, revealed there was a total of seventy-eight (78) residents in the building with four (4) residents receiving tube feeding.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Food Receiving and Storage", last revised 12/2008, revealed all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Other opened containers must be dated and sealed or covered during storage. Food Services, or other designated staff, will maintain clean food storage areas at all times.</p> <p>Interview with the Dietary Manager, on 03/25/15 at 9:05 AM, revealed there was no facility policy for staff use of hair nets while in the kitchen.)</p> <p>Observation and tour of the kitchen, on 03/24/15 at 8:55 AM, revealed the following opened and undated items in the refrigerator: One (1) block of butter; one (1) gallon of milk; one (1) pint of heavy cream; one (1) tub of chicken base; one (1) jar of mustard; one (1) package of bologna opened to air (dried out on the edges); bologna wrapped in foil not dated; boiled eggs dated 03/19/15; and one (1) quart of chocolate milk (employees). Further observation revealed the Dietary Manager in the kitchen without a hair net. Additionally, the meat slicer had nicks on the blade and was still in use.</p>	F 371	<p>2. Observation of the refrigerator by the dietary service manager on 04/16/2015 Revealed no unlabeled foods, all foods labeled, covered and dated, as well is no employee drinks in the refrigerator. In addition, Observation by the Administrator on April 15, 2015 revealed all staff wearing hairnets. All other equipment was inspected by the dietary services manager on April 15, 2015 to ensure no other equipment which needed repair was in use none was found.</p> <p>3. All dietary staff will be educated on labeling and dating of foods, the routine cleaning schedule, no personal items and refrigerator, the requirement to wear hairnet to cover hair and beards, and removing equipment in need of repair from service immediately. This education will be provided by the Dietary Services Manager.</p> <p>In addition, the Regional Dietician will re-educate the dietary services manager on use of hairnets, daily inspection for covered foods and outdated foods, and weekly inspection of equipment.</p>	

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F 371	Continued From page 61  Interview with the Dietary Manager, on 03/25/15 at 9:05 AM, revealed the normal procedures for any item open in the refrigerator was it must be labeled and dated as to when it was opened and any item greater than three (3) days old must be thrown out. She stated no employee was to keep personal food or drink items in the kitchen refrigerator and hair nets should be worn in the kitchen at all times. Additionally, she stated the meat slicer should not of been in use with nicks on the blade. Further interview revealed she was responsible for completing an audit daily and weekly for monitoring the refrigerators and freezers for any items that needed to be thrown out and checking the meat slicer.  Interview with the Registered Dietitian (RD), on 03/27/15 at 7:39 AM, revealed she expected if anything was not stored properly and dated it would be thrown out immediately and hair nets should be worn at all times. The RD stated if a piece of equipment was not in good working condition then it should not be in use. Further interview revealed she was only in the building once a month and the Dietary Manager was responsible for the safe and clean operation of the kitchen.	F 371	3. The dietary services manager will perform a weekly sanitation audit for at least twelve weeks. She will also audit her staff five times per week for 12 weeks to ensure they are wearing hairnets and to ensure no personal items are being stored in the refrigerator and all opened foods are labeled and stored appropriately. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly	
F 372 SS=E	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 372	F372 The dumpster door was closed immediately by Maintenance Director on March 24, 2015 as soon as it was discovered the doors were open.	5/11/15

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F 372	<p>Continued From page 62</p> <p>determined the facility failed to ensure disposal of garbage properly as evidenced by dumpster doors left open.</p> <p>The findings include:</p> <p>Interview with the Maintenance Director, on 03/24/15 at 10:30 AM, revealed as far as he knew there was no policy to address the dumpster slider door being closed</p> <p>General observations of the facility, on 03/24/15 at 10:00 AM, revealed the dumpster slider doors were left open.</p> <p>Further Interview with the Maintenance Director, on 03/24/15 at 10:30 AM, revealed the dumpster doors were to be closed at all times otherwise pests could get inside.</p> <p>Interview with the Director of Nursing (DON), on 03/26/15 at 3:10 PM, revealed the staff should close the dumpster doors after use.</p> <p>F 428 SS=D 483.80(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 372	<p>2.The administrator observed the dumpster doors being closed on April 15, 2015 and April 16, 2015.</p> <p>3. In addition, all nursing assistants and all dietary staff will be educated to ensure they understand the practice of ensuring the dumpster doors are closed at all times. This education will be provided by the Administrator, Director of Nursing, Assistant Director of Nursing or Unit Managers.</p> <p>4. The Administrator will make observations of the dumpster five times per week for four weeks then three times per week for eight weeks to ensure staff are closing the dumpster doors after use. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator,</p>	

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F 428	<p>Continued From page 63</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the pharmacy failed to ensure delivery of a now dose of Decadron for one of sixteen (16) sampled residents (Resident #9).</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #9 on 11/20/13 with diagnoses to include Anxiety, Hypothyroidism and Hypertension.</p> <p>Review of Nurses Notes, dated 03/04/15 at 5:06 PM, revealed the nurse phoned the physician related to the development of a rash to Resident #9's upper chest, arms and legs.</p> <p>Review of a Comprehensive Physician Order Sheet, dated 03/04/15 at 2:25 PM, revealed a telephone order for Decadron four (4) mg Intramuscular (IM) Now.</p> <p>Review of the March 2015 Medication Administration Record revealed the resident was administered Decadron 4 mg. IM on 03/05/15 at 6:30 PM approximately twenty-six (26) hours after the order was received to administer "now".</p> <p>Post survey interview with Licensed Practical Nurse (LPN) #4, on 04/10/15 at 9:32 AM, revealed she after checking the Emergency Drug Kit (EDK) and not finding the medication in the kit, she faxed the order to the pharmacy and followed up with a phone call. She stated she spoke with a female at the pharmacy and notified the female that she needed the Decadron stat. LPN #4 stated the female asked if it could be delivered</p>	F 428	<p>Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly.</p> <p>F428</p> <ol style="list-style-type: none"> <li>1. Resident # 9 received the ordered dose of Decadron on 03/05/2015 by a licensed nurse.</li> <li>2. By 05/10/15 the Director of Nursing, Assistant Director of Nursing and Unit Managers will complete an audit of all current resident's Medication Administration Record and the medication cart to ensure all medications have been delivered by the pharmacy and all are available. Any not available will be immediately delivered from the pharmacy.</li> <li>3. The General Manager of the pharmacy will re-educate all pharmacy staff by 05/10/15 on calling the facility with any delay in delivery of a stat dose of medication so staff</li> </ol>	5/11/15

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F 428	Continued From page 64 with the 9:00 PM medications and she told her no that it was needed stat. LPN #4 revealed the medication had not arrived by the time her shift ended at seven 7:00 PM so she reported that to the oncoming staff.  Interview with Unit Manager, Registered Nurse (RN) #2 , on 03/26/15 at 2:00 PM, revealed the Decadron wasn't received from the pharmacy on the day it was ordered and the error was not discovered until the following day. The Decadron was administered on 03/05/15 at 8:30 PM by Registered Nurse (RN) #2.  Interview with Pharmacist, on 03/27/15 at 10:15 AM, revealed an order was received from the pharmacy by fax on 03/04/15 at 2:22 PM for Resident #9 to have Decadron four (4) milligrams (mg) intramuscularly (IM) as a now order. The pharmacist reports that they returned a fax to the facility for them to check the Emergency Drug Kit (EDK) for the medication. The pharmacy received the information on 03/05/15 that the Decadron was not in the EDK. The Decadron was sent to the facility on 03/05/15 at 5:00 PM. He also advised that now or stat orders should be delivered within two (2) hours. He revealed the pharmacy staff thought the the Decadron was in the EDK box.	F 428	may notify the physician. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit the Medication Administration Records weekly for twelve weeks to ensure medications are administered in a timely manner per physician order. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly	
F 431 SS=D	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 accurate reconciliation; and determines that drug	F 431	F431 1. On 04/16/2015 the	5/11/15

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F 431	<p>Continued From page 65</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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 1978 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure medications used in the facility was labeled in accordance with currently accepted professional principles. (Observation of the medication cart for</p>	F 431	<p>identified open medications without a date were dated for the date of delivery from the pharmacy by the Unit Managers.</p> <ol style="list-style-type: none"> <li>By 05/10/15 the Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all medication carts to ensure all medications not unit dosed are dated when opened. Any undated will be dated the date of delivery.</li> <li>All licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Managers on the requirement to date all non- unit dose medications when opened.</li> <li>The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all med carts weekly for twelve weeks to ensure all non-unit dose medications are dated when opened. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are</li> </ol>	

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F 431	Continued From page 86 Hall I, ) revealed four (4) bottles of Miralax (laxative) open with no date, one (1) bottle of Milk of Magnesium (laxative) open with no date, one (1) bottle of Mylanta (antacid) open with no date, three (3) bottles of cough syrup open with no dates, three (3) bottles of sore throat spray open with no dates, and one (1) bottle of Tums (antacid tablets) open with no date.  The findings include:  Review of the facility's policy and procedure, titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles", last revised 01/01/13, revealed the facility staff should record the dated opened on the medication container when the medication has a shortened expiration date once opened."  Interview with Licensed Practical Nurse (LPN) #7, on 03/28/15 at 2:15 PM, revealed the medications listed above should have been dated when they were opened and she knew this was the facility's policy. She was unsure who opened the medications but knew it was her responsibility to date any medication when it was opened.  Interview with the Director of Nursing (DON), on 03/28/15 at 3:00 PM, revealed she expected the nurse who opened the medication initially to be the one to date the medication when it was opened.	F 431	identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly	
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	F 441	F441  1. Nursing Assistant # 8 was re-educated by the Director of Nursing on	5/11/15

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F 441	<p>Continued From page 67 to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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 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.</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</p>	F 441	<p>the requirement to bag all dirty linen before leaving room and the proper procedure to carry linens. On 04/17/2015 the Director of Nursing observed nursing assistant # 8 appropriately bagging and carrying linen.</p> <p>2. On 04/15/2015 and 04/16/2015 the Director of Nursing noted that staff were bagging linen prior to leaving room and carrying linen appropriately.</p> <p>3. By 05/10/15 all nursing assistants will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager on bagging dirty linen prior to leaving the room and the proper way to carry linen.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will make observations five times per week for twelve weeks of staff providing care to evaluate if dirty linens are bagged prior to leaving the room and linens are carried appropriately. The</p>	

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F 441	<p>Continued From page 68</p> <p>and review of facility policy and procedure, it was determined the facility failed to 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 related to inappropriate transportation of soiled linen.</p> <p>The findings include:</p> <p>Review of the facility policy and procedure, titled "Infection Control Tracking and Trending Policy and Procedure", dated 09/13, revealed the purpose of the Infection Control Policy and Procedure was to prevent the spread of infection and provide appropriate education for staff and residents concerning infection control.</p> <p>Observation of Certified Nurse Aide (CNA) #8, on 3/25/15 at 7:25 AM, revealed the CNA carried several articles of soiled linen out of a resident's room without the soiled linen being contained. CNA #8 had the soiled linen in her hands and against her arms while walking out of resident's room into the hallway.</p> <p>Interview with CNA #6, on 03/27/25 at 7:20 AM, revealed the CNA should bag all soiled linen in bags prior to leaving a resident's room and take the soiled lined to the soiled linen room.</p> <p>Interview with CNA #7, on 03/27/25 at 7:37 AM, revealed soiled linen had to be bagged up before it was brought out of a resident's rooms.</p> <p>Interview with Unit Manager Licensed Practical Nurse (LPN) #1, on 03/25/15 at 8:10 AM, revealed she expected soiled linen to have been bagged before being brought out of the resident</p>	F 441	<p>results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly</p>	

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F 441	Continued From page 69 rooms.	F 441			
F 514	<p>Interview with the Director of Nursing (DON), on 03/26/15 at 1:12 PM, revealed she expected staff to bag soiled linen before bringing it out of a resident's room.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy revealed the facility failed to ensure the clinical record was complete for one (1) of sixteen (16) sampled residents (Resident #3). Resident #3 was ordered a treatment of a rash and the licensed nurse failed to document the treatment was completed as ordered.</p> <p>The findings include:</p>	F 514	<p>F514</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing observed on 04/15/2015 the treatments for resident #3 including oxygen saturation were documented.</li> <li>2. On 04/16/2015 the Director of Nursing noted that all treatments and Oxygen saturation were documented.</li> <li>3. By 05/10/15 all licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager on documentation of treatments and oxygen saturation requirement.</li> <li>4. The Director of Nursing Assistant Director of Nursing or Unit managers will audit all the Treatment Administration Records weekly for at least twelve weeks to validate staff are documenting treatments</li> </ol>	5/11/15	

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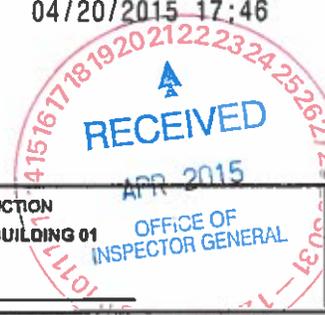
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/27/2015
NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(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 514	<p>Continued From page 70</p> <p>Record review revealed the facility admitted Resident #3 on 04/15/09, with diagnoses which included Hypertension, Anxiety, Alzheimer's Disease, and Rash. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/05/15, revealed the facility identified the resident's cognitive status as severely impaired with a Brief Interview of Mental Status score of "99" which indicated the resident was not interviewable.</p> <p>Review of the Physician's Order, dated 03/11/15, revealed to apply Triamcinolone (corticosteroid) Cream 0.1% to rash on body twice a day (BID)</p> <p>Review of the March 2015 Treatment Administration Record (TAR) revealed a treatment for Triamcinolone (corticosteroid) Cream 0.1% to rash on body BID (7:00 AM and 7:00 PM) starting on 03/12/15. Further review revealed the 7:00 PM dose was not initialed as completed on 03/13/15-03/16/15, and 03/20/15-03/23/15.</p> <p>Review of a Physician Order, dated March 2015, revealed to obtain oxygen (O2) saturation levels daily.</p> <p>Further review of the March 2015 TAR revealed to obtain O2 saturation daily at 6:00 AM with blanks noted twelve (12) blanks noted between 03/01/15 and 03/24/15.</p> <p>Interview with Registered Nurse (RN) #5 who worked 7:00 PM to 7:00 AM, on 03/27/15 at 11:30 AM, revealed she always applied the treatment cream and obtained O2 saturation but she doesn't have time to initial the TAR to indicate the treatment was completed and O2 sats were</p>	F 514	<p>and oxygen saturations. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Services Manager, Social Services Director and Maintenance Director with the Medical Director attending at least quarterly</p>		

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F 514	Continued From page 71 obtained. She stated she leaves a lot of blanks on the TAR because of this.  Interview with Licensed Practical Nurse (LPN) #5 who works 7:00 PM to 7:00 AM, on 03/27/15 at 7:50 AM revealed she knows the nurse who works on the hall and she knows the nurse completes the treatments and obtains O2 saturation levels but the nurse fails to document them.  Interview with the Director of Nursing (DON), on 03/25/15 at 11:00 AM, revealed she expected the nurses to document the treatments when administered and O2 saturations when obtained. She stated she feel the nurse just failed to document.	F 514			

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 28 smoke detectors and 197 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator with unknown installation date. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 03/25/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety (90) beds with a census of seventy-four (74) 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</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dan Stockdale* TITLE: *Interim Administrator* (X6) DATE: *4/20/15*

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

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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K 000  K 025 SS=F	<p>Continued From page 1 Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>1) Observation, on 03/25/15 at 9:30 AM, with the Maintenance Supervisor revealed the use of unrated joint compound to seal penetrations in</p>	K 000  K 025	<p>as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>K25</p> <p>The joint compound used to seal the penetration of the concrete block wall used as a smoke barrier at the exit by room 16 was replaced with mortar on April, 10th, 2015.</p> <p>The joint compound used to seal the penetration in the concrete block wall above the ceiling at the administrators office was replaced with mortar on April 10, 2015.</p> <p>The expanding foam used to seal the penetration of the smoke wall above the ceiling located by room 26 was replaced with mortar on April 10, 2015.</p> <p>The expanding foam use to seal the penetration of the concrete block wall</p>	5/11/15

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K 025	<p>Continued From page 2</p> <p>the concrete block wall being used as a smoke barrier extending above the ceiling located at the Exit by Room #18.</p> <p>Interview, on 03/25/15 at 9:31 AM, with the Maintenance Supervisor revealed he was not aware the requirements for sealing penetrations in smoke barriers.</p> <p>2) Observation, on 03/25/15 at 9:35 AM, with the Maintenance Supervisor revealed the use of unrated joint compound to seal penetrations in the concrete block wall being used as a smoke barrier extending above the ceiling located at the Administrators Office.</p> <p>Interview, on 03/25/15 at 9:36 AM, with the Maintenance Supervisor revealed he was not aware the requirements for sealing penetrations in smoke barriers.</p> <p>3) Observation, on 03/25/15 at 9:40 AM, with the Maintenance Supervisor revealed the use of expandable foam to seal penetrations in the smoke wall being extending above the ceiling located by Room #26.</p> <p>Interview, on 03/25/15 at 9:41 AM, with the Maintenance Supervisor revealed he was not aware the requirements for sealing penetrations in smoke barriers.</p> <p>4) Observation, on 03/25/15 at 9:42 AM, with the Maintenance Supervisor revealed the use of expandable foam and unrated joint compound to seal penetrations in the concrete block wall being used as a smoke barrier extending above the ceiling located at the Exit by Room #42.</p>	K 025	<p>extending above the ceiling at the exit by room 42 was replaced with mortar on April 10, 2015.</p> <p>The Maintenance Director will be educated to use like kind materials to seal penetrations.</p> <p>All firewalls and the entire building were checked to ensure the use of proper material to seal penetrations on April 10, 2015. One other area was found and repaired immediately.</p> <p>In the future, all contractors going into the attic to make repairs will be informed of the requirement to use the proper material when ceiling any penetrations should any penetrations occur. The Maintenance Director will look at all barrier walls after completion of any work to ensure compliance.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	

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K 025	<p>Continued From page 3</p> <p>Interview, on 03/25/15 at 9:43 AM, with the Maintenance Supervisor revealed he was not aware the requirements for sealing penetrations in smoke barriers.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</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 automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition)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</p>	K 025			

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K 025	Continued From page 4 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. 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.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions:	K 025			

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K 025	Continued From page 5 (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=D	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 determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).  The findings include:	K 029	K29 A door closure was placed on the office door of the director of nursing on March 31, 2015.  All files being stored in the unrated old bathroom located in the therapy room have been removed.  The Maintenance Director will be educated regarding the proper use of door closures as well as proper storage of combustible materials.  All new hires will be educated regarding the proper storage of combustible material.  All offices in the building will be audited to ensure any offices containing a hazardous amount of combustibles will have a door closure installed	5/11/15

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K 029	<p>Continued From page 6</p> <p>Observation, on 03/25/15 at 11:20 AM, with the Maintenance Supervisor revealed a hazardous amount of paper storage located in the Director of Nursing Office. The door was not equipped with a self-closing device to keep the door closed.</p> <p>Interview, on 03/25/15 at 11:21 AM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>Observation, on 03/25/15 at 1:27 PM, with the Maintenance Supervisor revealed Medical Records were being stored in an unrated old bathroom located in the Therapy Room.</p> <p>Interview, on 03/25/15 at 1:28 PM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/125/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 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</p>	K 029	<p>immediately.</p> <p>All rooms in the building will be audited to identify any other rooms that are unrated for files being stored. If any are found, they will be removed immediately.</p> <p>All offices in the building will be audited weekly for 12 weeks to ensure any offices containing a hazardous amount of combustibles will have a door closure installed immediately or the hazardous files removed.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	
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K 029	Continued From page 7 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 <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.  Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance	K 029		

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K 029	Continued From page 8 with 7.2.1.8.2.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by:	K 062	K62 The car was immediately removed from the no parking zone by the fire department connection.  All new employees will be educated upon hire and current employees have been	5/11/15	

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 NORTH ELM ST. HENDERSON, KY 42420	

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K 062	<p>Continued From page 9</p> <p>Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/25/15 at 2:10 PM, with the Maintenance Supervisor revealed the Fire Department Connection located outside was blocked by a car parking in a no parking zone.</p> <p>Interview, on 10/25/15 at 2:11 PM, with the Maintenance Supervisor revealed cars routinely disregarded the no parking signs</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 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.</p> <p>Exception: Valves and fire department</p>	K 062	<p>in serviced in regard to not parking in the no parking zone beside the fire department connection</p> <p>All employees will be in service to ensure everyone is aware of the no parking area beside the fire department connection.</p> <p>The Maintenance Director or designee will check the no parking zone five times weekly for a period of four weeks to ensure no one is parked in the no parking zone. If no additional issues are found the audits more reduced to two times weekly for an additional eight weeks and weekly thereafter. Any cars found to be parked in a no parking zone will be moved or towed immediately.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	
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K 062	Continued From page 10 connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1	K 062		

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K 062	<p>Continued From page 11</p> <p>Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p> <p>Component Activity Frequency Reference</p> <p>Control Valves</p> <p>Sealed Inspection Weekly 9-3.3.1</p> <p>Locked Inspection Monthly 9-3.3.1 Exception No. 1</p> <p>Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1</p> <p>Alarm Valves</p> <p>Exterior Inspection Monthly 9-4.1.1</p> <p>Interior Inspection 5 years 9-4.1.2</p> <p>Strainers, filters, orifices Inspection 5 years 9-4.1.2</p> <p>Check Valves</p> <p>Interior Inspection 5 years 9-4.2.1</p> <p>Preaction/Deluge Valves</p> <p>Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1</p> <p>Exterior Inspection Monthly 9-4.3.1.2</p> <p>Interior Inspection Annually/5 years 9-4.3.1.3</p> <p>Strainers, filters, orifices Inspection 5 years 9-4.3.1.4</p> <p>Dry Pipe Valves/Quick-Opening Devices</p> <p>Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1</p> <p>Exterior Inspection Monthly 9-4.4.1.3</p> <p>Interior Inspection Annually 9-4.4.1.4</p> <p>Strainers, filters, orifices Inspection 5 years 9-4.4.1.5</p> <p>Pressure Reducing and Relief Valves</p> <p>Sprinkler systems Inspection Quarterly 9-5.1.1</p> <p>Hose connections Inspection Quarterly 9-5.2.1</p> <p>Hose racks Inspection Quarterly 9-5.3.1</p>	K 062		
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K 062	Continued From page 12 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.8, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually	K 062		

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K 062	Continued From page 13 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the staff was properly equipped for safe smoking, in</p>	K 066	<p>K66</p> <p>The cigarette butts outside the back entrance door to the 200 hall were removed.</p> <p>Cigarette butts around the entire building have been removed and cigarette urns installed at the therapy and kitchen entrances.</p> <p>All new employees will be educated upon hire and current employees will be in serviced to ensure everyone is aware of the proper disposal of cigarette butts.</p> <p>The Maintenance Director or designee will check the entrance by the 200 hall five times weekly for a</p>	5/11/15

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K 066	<p>Continued From page 14</p> <p>accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking area. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/25/15 at 11:45 AM, with the Maintenance Supervisor revealed a large quantity of cigarette butts in the mulch of the flower bed outside the Back Entrance Door to the 200 Hall. This was not a designated smoking area.</p> <p>Interview, on 03/25/15 at 11:46 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for smoking areas.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that</p>	K 066	<p>period of four weeks to ensure an excessive amount of cigarette butts are not present. If no additional issues are found the audits will be reduced to two times weekly for a period of eight weeks. Cigarette butts found will be removed immediately.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	

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K 066	Continued From page 15 read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.  Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K72 The three medicine carts in the egress path on hall one were removed immediately.  The dish carts located in the egress path of the front hall by the kitchen were removed immediately.	5/11/15

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K 072	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/25/15 at 11:10 AM, with the Maintenance Supervisor revealed the storage of three (3) Medicine Carts in the egress path located in Hall One (1).</p> <p>Interview, on 03/25/15 at 11:11 AM, with the Maintenance Supervisor revealed the items were routinely stored in this location.</p> <p>Observation, on 03/25/15 at 2:14 PM, with the Maintenance Supervisor revealed the storage of dish carts located in the egress path of the Front Hall by the Kitchen.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p>	K 072	<p>All egress paths have been audited to ensure all medicine carts and dish carts not currently in use are removed.</p> <p>All new employees will be educated upon hire and current employees have been in serviced in regard to maintaining paths of egress and removing obstacles to the path of egress when items are not in use.</p> <p>The Maintenance Director or his designee will monitor paths of egress throughout the facility five times weekly to ensure medicine carts and dish carts that are not being used are not blocking the path of egress. If no issues were found during the initial four weeks of audits the audits will be reduced to two times per week for eight weeks. If any issues are noted they will be corrected immediately.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	
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K 072	Continued From page 17 Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 072		
K 075 SS=D	Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure linen or trash collection receptacles with capacities	K 075	K075 The trash container with the capacity in excess of 32 gallons was removed from the front hall by the dining room.  All other areas of the building will be audited to ensure no trash containers with the capacity in excess of 32 gallons are being stored in an area that is unattended. If any are found they will be removed immediately and replaced with trash containers with	5/11/15

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
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K 075	<p>Continued From page 18</p> <p>greater than 32 gallon were stored in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/25/15 at 9:50 AM, with the Maintenance Supervisor revealed a trash container with a capacity of over thirty two (32) gallons was being stored in the Front Hall by the Dining Room.</p> <p>Interview, on 03/25/15 at 9:51 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft<sup>2</sup> (20.4 L/m<sup>2</sup>). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft<sup>2</sup> (5.9-m<sup>2</sup>) area. Mobile soiled</p>	K 075	<p>the capacity of 32 gallons or less.</p> <p>The Central Supply clerk, the Dietary Services Manager and Maintenance Director will be in-serviced on proper container sizes for trash disposal containment.</p> <p>The Maintenance Director or his designee will audit the building weekly for period of 12 weeks to ensure no trash containers in excess of 32 gallons are in use in unattended areas with resident access. If any are found they will be removed immediately.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188402	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420	

(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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K 075	Continued From page 19 linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).  The findings include:	K 076	K76 The oxygen tanks were removed from the middle hall medicine room to the oxygen room.  All rooms throughout the building will be checked to ensure there are no oxygen cylinders within 5 feet of combustible storage.  All new employees will be educated upon hire and current employees will be in serviced to ensure no one is storing oxygen cylinders within 5 feet of combustible material.  The Maintenance Director or designee will audit all rooms in the building weekly for a period of 12 weeks to ensure no oxygen	5/11/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
(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 076	Continued From page 20  Observation, on 03/25/15 at 11:25 AM, with the Maintenance Supervisor revealed combustible storage was being stored within five (5) feet of the oxygen tanks located in the Middle Hall Medicine Room. Further observation revealed an Ignition source was installed below five (5) from the floor.  Interview, on 03/25/15 at 11:26 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for piped in medical gas.  The census of seventy-four (74) was verified by the Administrator, on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.  Reference: NFPA 101 (2000 edition)  19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.  8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.	K 076	tanks are within 5 feet of combustible materials. If any oxygen tanks are found within 5 feet of combustible materials the tank will be removed immediately.  Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.	

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
(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 076	Continued From page 21 (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ¼ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED	K 076		

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
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K 076	Continued From page 22	K 076		
K 147	WITHIN NO SMOKING	K 147		
SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety (90) beds and at the time of the survey, the census was seventy-four (74).  The findings include:  Observation, on 03/25/15 at 1:29 PM, with the Maintenance Supervisor revealed a coffee maker was plugged into a power strip located in the Therapy Room.  Interview, on 03/25/15 at 1:30 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for the proper use of power strips.  Observation, on 03/25/15 at 2:20 PM, with the Maintenance Supervisor revealed a refrigerator and a microwave were plugged into a power strip located in the Business Office.	K147 The coffee maker in the therapy room was unplugged immediately.  The refrigerator and microwave plugged into the power strip in the business office were unplugged and the power strip removed immediately.  A new outlet was installed in the therapy room for the coffee maker. The refrigerator microwave in the business office were rearranged in the office to ensure they were plugged in directly to outlets.  All new employees will be educated upon hire and current employees will be in serviced to ensure they understand the types of items that may be plugged into power strips and the type of power strips that are acceptable.  All rooms in the building will be checked weekly for	5/11/15	

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
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K 147	<p>Continued From page 23</p> <p>Interview, on 03/25/15 at 2:21 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for the proper use of power strips.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D)</p>	K 147	<p>a period of 12 weeks by the Maintenance Director and weekly thereafter to ensure no unapproved items are plugged into improper power strips.</p> <p>Any issues of noncompliance will be corrected immediately and reported to the QA committee for update and follow up to ensure ongoing compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>HENDERSON NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 NORTH ELM ST. HENDERSON, KY 42420</b>		
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K 147	Continued From page 24 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		