

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

PRINTED: 10/08/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2010
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NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey and complaint investigations, KY00014936, KY00014870, KY00014600, and KY00014111 were conducted 09/21/10 through 09/24/10. Deficiencies were cited from the standard health survey with the highest scope and severity of a "G". KY00014936, KY00014870, KY00014600, and KY00014111 were found to be substantiated. A Life Safety Code survey was conducted on 09/22/10 and deficiencies were cited.</p>	F 000	<p>Facility Administrator states that the plan of correction contained here-in constitutes the facilities allegation of compliance with all deficiencies cited, that no separate notification of compliance is required by virtue of this allegation of compliance, and that this allegation of compliance may presume the facility's compliance until substantiated by a revisit or other means.</p>	
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to promptly and actively seek a resolution and keep the residents appropriately apprised of it progress toward the resolution of greivances. Two (2) of twenty-seven (27) sampled residents (Residents #25 and #26), had not recieved a response or resolution to their grievances.</p> <p>The findings include:  Review of the Grievance Policy (undated) revealed; A resident has the right to voice grievances with respect to treatment of care that</p>	F 166	<p>F 166 Resident # 25 and # 26 were interviewed regarding allegations of missing items. Follow up has been provided to resident #25 and #26 by the Social Services Director.</p> <p>The Social Services Director and Social Services Assistant will have additional training provided by Kara Meredith, Administrator on 10-19-10. All staff will receive additional training related to the Grievances and Missing Items Policy and Procedure provided by the ADON on 10-19-10. The Activity Director will review the Grievances and Missing Items Policy and Procedure at the next scheduled residents council meeting on 10-22-10.</p> <p>The Social Services Assistant will review all missing items/grievances weekly to ensure that appropriate follow up has occurred. Any concerns identified will be addressed immediately.</p> <p>The Social Services Assistant will present a report of her findings to the QA Committee quarterly for their review.</p>	10-26-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Kara Meredith</i>	TITLE <i>X Administrator</i>	(X6) DATE 10-18-10
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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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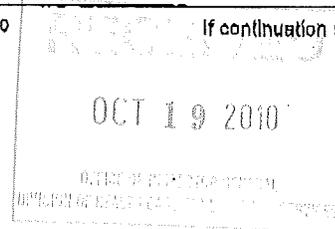
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F 166	<p>Continued From page 1</p> <p>is, or fails to be furnished, without discrimination of reprisal for voicing the grievance. Prompt efforts by the facility will be provided to resolve grievances the resident may have, including those with respect to the behavior of other residents. Facility encourages the resident to discuss any concerns he/she may have with nurse supervisor on duty.</p> <p>Review of the Resident's Possessions/Missing Items Policy And Procedure (undated) revealed: 1) On admission, the resident and his/her responsible party will be advised of the availability of locked drawers in each resident room. The resident will be advised against keeping anything of great monetary value in the room. 2) If a report of a missing item is received, the staff member receiving the report will fill out a Missing Item form, including a description of the item and the date last seen. 3) The Missing Item form will be forward to the Director of Resident Services (Social Worker), who in turn will give a copy to the appropriate Nurses Station, the Director of Nursing and Housekeeping Supervisor. 4) Each department will do a follow-up investigation, document results on the form, and return it to the Director of Resident Services. 5) The Director of Resident Services will keep a copy of these forms for a reasonable length of time and periodically analyze the reports to note any problem areas. 6) If the investigation of Missing Items results in the finding of criminal activity, the Administrator will be immediately notified. The Administrator, in turn, will file a report with the agencies as required by state law.</p> <p>A Resident Council Group Interview Meeting was conducted on 09/22/10, at 9:30am. Nine (9) alert and oriented residents attended the Group</p>	F 166		
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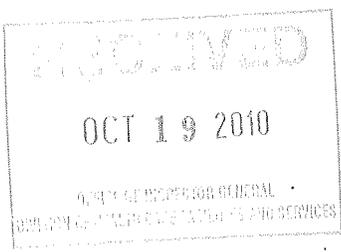
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F 166	<p>Continued From page 2</p> <p>Interview. During the Group Interview, two (2) of the nine (9) residents (Residents #25; #26) verbalized they had not received any response or resolution to their grievances of missing items and missing money. Residents #25 and #26 further stated it had been reported to the nursing staff.</p> <p>An interview with Resident #25 at 9:30am on 09/22/10 revealed that his/her missing money (\$3.00) from his/her room happened approximately 6 (six) months ago. He/She further stated that he/she had notified the head nurse regarding the missing money and there had been no follow-up.</p> <p>An interview with Resident #26 at 9:30am on 09/22/10 revealed that he/she had voiced to a staff member that several missing items (ie clothing, what knots) were taken from his/her room. He/She further stated that there had been no follow up.</p> <p>An interview with the Director of Nurses at 10:35am on 09/23/10 revealed that she nor her staff would have the time to write up all grievances every day. She further stated it was the Social Worker's responsibility to document and follow up on grievances and missing items.</p> <p>An interview with the facility Social Worker at 10:45am on 09/23/10 revealed that the Social Worker had been employed since January 2010. She stated she had never used the grievance log and that the Grievance Policy (undated) was found in her office approximately two (2) weeks ago. She further stated that her process for handling grievances was to document concerns or grievances in the chart, then follow up with the</p>	F 166		
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F 166	Continued From page 3 appropriate department head regarding the grievances. The Social Worker stated that she had no knowledge of Residents' #25 and #26 grievances.	F 166		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225	<p>Resident # 22 is no longer at the facility.</p> <p>Staff were re-interviewed and more detailed statements were obtained related to resident #3's right shoulder dislocation and it was determined that it was not an incident of unknown origin.</p> <p>DON/ADON and Unit Managers will audit the past 3 months of incidents to ensure that the facility abuse prohibition protocol was followed and appropriate/timely measures were taken regarding any potential allegations of abuse.</p> <p>Licensed staff will be re-educated by ADON on 10-19-10 regarding incident reports investigative protocol for bruises, skin tears and injury of unknown origin.</p> <p>A full staff meeting was conducted on 9-28-10 by Deloris Jacobs, DON during which the abuse prohibition policy was reviewed.</p>	10-26-10



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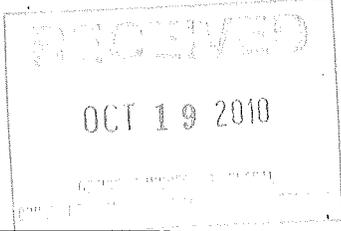
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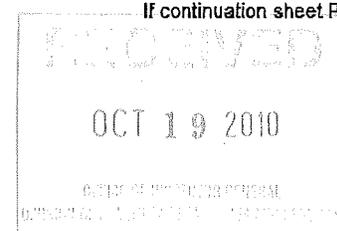
F 225	<p>Continued From page 4</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to report allegations of physical abuse in a timely manner and thoroughly investigate allegations of abuse for two (2) of twenty-seven (27) sampled residents. The facility failed to report an allegation of physical abuse in a timely manner for Resident #22. It was also determined that the facility failed to report an injury of unknown source and provide sufficient evidence of a thorough investigation into an injury regarding Resident #3.</p> <p>The findings include:  Interview with Certified Nursing Assistant (CNA) #11 on 09/21/10 at 1:25pm revealed that as she was coming on 3-11 shift, CNA #11 noticed Resident #22 crying. Resident #22 had told CNA #11 that Licensed Practical Nurse (LPN) #5, while doing a dressing change to coccyx, patted Resident #22 on his/her bottom twenty-two (22) times. CNA #11 stated that she told her nurse who was LPN #5 at 3:30pm on 03/13/10 of the incident. The Unit Coordinator was not available related to it being the weekend.</p>	F 225	<p>The DON/ADON and Administrator review all incident reports and follow up immediately on any incidents of unknown origin.</p> <p>All staff are trained on the Abuse Prohibition Policy upon hire and resident abuse training will be provided quarterly by the DON/ADON or Social Services Department.</p> <p>Any concerns identified via review of incidents or concerns brought to the DON/ADON or Administrator will be addressed immediately and reviewed by the QA Committee quarterly for any further educational/correctional needs.</p>	
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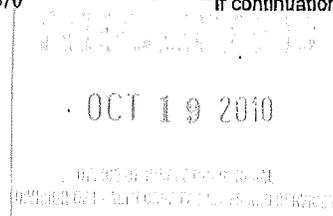
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F 225	Continued From page 5  Interview with the LPN #5 on 09/21/10 at 1:43pm revealed that he had done a dressing change with a nurse on the day of the incident. LPN #5 further stated that CNA #11 asked him about 14 to 15 feet away, had he been in the room with Resident #22. LPN #6 responded "no". LPN #5 further stated there was no clear reporting from CNA #11. When LPN #5 was asked what type of training he received from the facility on reporting abuse, LPN #5 stated that he could not remember.  Interview with LPN #1 on 09/22/10 at 9:41am revealed that she did not work the evening of the incident. LPN #1 further stated that the facility did not find out about the incident until 03/17/10 after the family reported the concern to the facility. LPN #1 voiced that she then began to question CNA #11 and asked her who did she tell the incident too. CNA #11 then voiced that she told LPN #5. LPN #1 further stated that LPN #5 stated that he was not aware that he was to report the information given to him by CNA #11.  Interview with the Director of Nursing (DON) on 09/21/10 at 11:19am revealed that staff were instructed on abuse when they were hired and a couple times a year. The DON further stated that staff are instructed to report abuse as soon as it happens.  Interview with the Administrator on 09/21/10 at 2:17pm revealed that staff are given a new hire check off list. Staff are taught on abuse and checked off during orientation. Staff are to report abuse immediately to the House Supervisor and DON.	F 225		



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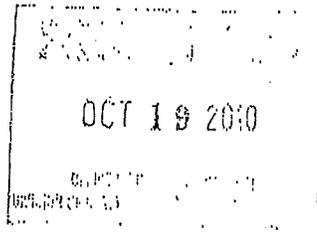
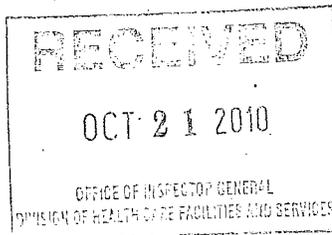
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F 225	<p>Continued From page 6</p> <p>Record review of Nurse's Notes from 08/10/10 at 1:50am stated CNA reported Resident #3 complained of right shoulder pain and upon nursing assessment, a physician order was obtained to transport the resident to a local hospital for medical imaging. The Nurse's Notes stated that the shoulder injury was unwitnessed by staff. Nurse's Notes reported the resident returned to facility from the hospital with a diagnosis of right shoulder dislocation and was wearing a sling on right arm after reduction of the right shoulder.</p> <p>Record review of a document prepared by the Director of Nursing (DON), dated 08/10/10 revealed the DON spoke with aides working from 08/6/10 through 08/9/10, the shower aides, and three nurses. The documentation did not include the names of the aides, or shower aides. No direct statements were obtained from the individuals who were interviewed by DON, and there was no report of questioning staff about possible abuse.</p> <p>Observations on 09/21/10 at 10:10am, 09/22/10 at 10:30am, and 09/23/10 at 10:30am revealed Resident #3 sitting in wheelchair with a sling to the right arm.</p> <p>Interview on 09/23/10 at 3:00pm with the DON revealed she was called during the night of 08/10/10 and was advised of the unwitnessed/unexplained injury to Resident #3. She completed an incident report the morning of 08/10/10, but stated she could not find the report. The DON said she did not report the incident because she determined there was a reasonable explanation for the injury. The DON said she completed a thorough investigation and</p>	F 225		



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F 225	Continued From page 7	F 225		
F 241 SS=E	<p>concluded that Resident #3, diagnosed with Huntington's Disease, sustained the injury as a result of the "jerky constant movement" which caused dislocation of the joint.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews it was determined the facility failed to promote care and provide an environment for residents in a manner that would enhance a resident's dignity, respect and individuality for three (3) sampled and one unsampled residents (Resident #8, #2, and #27) of twenty-seven (27) sampled residents. During meal service a staff member was observed standing up while feeding a resident, staff addressed residents as "feeders", and failed to answer call lights and alarms timely.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #8 revealed the resident was admitted on 08/04/09 with diagnoses of Alzheimer's, Diabetes, HTN. The record also revealed that Resident #8 had been a marine and would normally awaken around 7am.</p> <p>Observation during initial tour at 5:50am on 09/21/10, noted that Resident #8 was up in</p>	<p>F 241</p> <p>The Administrator, Director of Nursing and their designee(s) will be responsible for monitoring resident #8 and resident #2 for appropriate interactions between the identified residents and staff. A full staff in-service was conducted by the Director of Nursing on 9-28-10 to re-educate staff on what types of responses and behaviors would honor dignity, respect and individuality of residents. Another full staff meeting will be conducted by the Administrator or her designee on 10-19-10 to re-iterate the importance of interacting with residents in a manner that honors their dignity, respect and individuality and reading F 241 observations as written on the statement of deficiencies. Resident #27 is/was an unsampled resident therefore we cannot address specific details of correction for resident # 27.</p> <p>Tools have been developed to monitor meal service, interaction(s), call light/alarm monitoring and staff interactions with residents. Administrative Staff (Administrator, DON, ADON, Social Worker, Social Services Assistant) and other licensed personnel will be responsible for conducting the audits. The audits will be completed daily for 2 weeks, 3 days a week for 2 weeks and a minimum of 3 times a week for 30 days and randomly thereafter. Any identified concerns will be addressed immediately.</p>	10-26-10	



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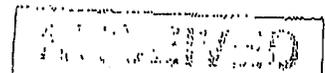
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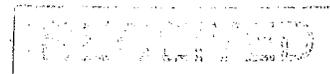
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F 241	<p>Continued From page 8</p> <p>his/her wheelchair (w/c) outside of room 511 and the hallway was dark. During the initial tour with LPN #7, interview revealed Resident #8 was the night shift's responsibility to get up for the day.</p> <p>Observations on 09/21/10 at 10:10am, 11:05am, 11:30am, 1:30pm, 3:00pm and 09/22/10 at 8:55am, 10:00am, 10:40am, 11:10am, 12noon revealed Resident #8 self propelling w/ch or sitting in the hallway or activity room alone. Observation on 09/22/10 during the breakfast meal revealed no interaction from staff to Resident #8 during the meal service.</p> <p>Observation of the 500 hallway on 09/24/10 from 8:10am until 9:10am revealed twenty three (23) healthcare staff or facility employees pass Resident #8 in his/her w/c at the entrance of the 500 hallway and never acknowledge Resident #8's presence. Further observation revealed that two (2) different employees spoke and hugged another resident directly across from Resident #8, but never acknowledged Resident #8's presence.</p> <p>Observation at 10:40am on 09/24/10 noted that after the surveyor interview with LPN #1, she spoke and touched Resident #8. Resident #8 then made eye contact with LPN #1 and smiled. LPN #1 transported Resident #8 via w/c outside.</p> <p>Interview with CNA #3 at 9:30am on 09/24/10 on the 500 hallway as she immediately passed Resident #8 revealed she was unaware of her actions in regards to acknowledging one resident's presence and not acknowledging Resident #8's presence. She further stated she would feel sad if someone didn't speak to her in the morning.</p>	F 241	<p>The ADON or Social Worker will request permission from the Residents Council to address the group monthly to solicit their input on how staff is progressing at honoring dignity, respect and individuality. Any identified concerns will be addressed immediately.</p> <p>Results of meal service, interaction(s), call light/alarm monitoring and staff interactions tools will reviewed by the QA Committee quarterly.</p> <p><b>Addendum</b> Resident #27 has been followed up with by Social Services regarding staff response. Social Services will continue to follow up with resident #27 for any future concerns 5 days a week for 2 weeks, 3 days a week for 2 weeks and a minimum of 3 times a week for 30 days and randomly thereafter.</p>	10-21-10
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 OCT 19 2010  
 OFFICE OF INSPECTOR GENERAL  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES

  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/24/2010
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 241	<p>Continued From page 9</p> <p>Interview with the Maintenance Assistaht at 9:40am on 09/24/10 in front of the 500 nurse's desk revealed he is very familiar with Resident #8 and was unaware of not acknowledging Resident #8's presence. He further stated he would feel kind of sad if no one spoke to him in the morning.</p> <p>Interview with CNA #2 at 9:50am on 09/24/10 in the dining room revealed she was very familiar with Resident #8 and was unaware of her actions of not acknowledging Resident #8, but she was trying to stay focus on getting morning work completed. She further stated if no one spoke to her in the morning, it would make her feel unimportant and was rude.</p> <p>Interview with a housekeeper at 10:10am on 09/24/10 revealed she was aware and familiar of Resident #8. She also stated she was aware of her action of speaking and hugging the other resident in the presence of Resident #8. She stated it was "ok to not speak because he is not aware."</p> <p>Interview with DON at 10:20am on 09/24/10 revealed she was unaware of passing Resident #8 on four (4) occasions without speaking or acknowledging the resident. She stated that Resident #8 was not cognitively intact; however, that is not a reason to not speak to someone. She further stated that it was not intentional, and that she looks after all the "little people". She also stated it would not feel good if someone didn't speak in the morning.</p> <p>Interview with the Medical Record Director at 10:30am on 09/24/10 revealed she was aware of Resident #8; however, she was unaware of not acknowledging Resident #8. She stated she just</p>	F 241		

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NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 688 ROGERSVILLE RD. RADCLIFF, KY 40160
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F 241	<p>Continued From page 10</p> <p>wasn't paying attention. She also stated it would make her feel ignored and upset if someone didn't speak in the morning.</p> <p>Interview with LPN #1 at 10:40am on 09/24/10 revealed she is very familiar with Resident #8; however, she was unaware of not acknowledging Resident #8. She stated it was not intentional. She also stated that she would feel lonely if no one spoke to her in the morning.</p> <p>Observation of lunch in the East Dining Room on 09/22/10 at 1:00pm revealed CNA #7 stood up while feeding an unsampled resident. She remained standing while feeding the resident and did not sit down with the resident.</p> <p>Interview with CNA #7 on 09/24/10 at 12:25pm revealed that the CNA had worked at the facility for two years. When asked what she had been taught about feeding residents she responded she was taught to sit down with the residents while feeding them, but sometimes there are not enough chairs readily available and it was crowded, so she stands while feeding the residents. She acknowledged it was important to sit down with the residents when feeding them because it made the resident more comfortable, instead of the staff person appearing to just be rushed through a task. She stated that although she knows sitting down with the residents was the proper way to feed them, she just failed to always do it that way. She also stated that inservices and CNA meetings were done on a weekly basis for all CNA activities, and this was something that was taught to the CNAs at the inservices.</p>	F 241	<div data-bbox="971 1465 1284 1696" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>OCT 19 2010</p> <p>OFFICE OF INSPECTION AND GENERAL INVESTIGATION</p> </div>	
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F 241	<p>Continued From page 11</p> <p>Observation on 09/21/10 at 8:40am revealed Resident #2 sitting at the table in the dining room. Staff were observed setting up a breakfast tray. After staff prepared coffee, Resident #2 stated, "I wish you had not put that sugar in my coffee". The CNA stated "but you told me to". The CNA never offered the resident a new cup of coffee.</p> <p>Continued breakfast meal observation revealed two (2) unsampled residents in Geri chairs. Two (2) CNA's were observed to call out over the dining room these residents, identified by name, are feeders. CNA #8 went over to one of the unsampled residents in the Geri chair and proceeded to set the resident up without explaining to the resident what she was doing. The resident got startled and yelled out.</p> <p>Observation on 09/23/10 at 2:15pm revealed an alarm sounded from the room of Resident #27. One staff member (Physical Therapy Assistant) was observed to walk by the room two times and did not respond.</p> <p>Observation on 09/23/10 at 2:30pm revealed the alarm from the room of Resident #27 stopped without staff entering the room. Upon entering the room, Resident #27 was observed getting into the wheelchair that had a pressure alarm. Resident #27 stated they had just gotten out to go to the bathroom, and stated "I can't wait on them, it takes too long for them to get to me".</p> <p>Interview conducted during the group meeting on 09/22/10 at 9:30am revealed the residents voicing that there is enough staff but question if all the staff care.</p> <p>Interview with the DON on 09/23/10 at 3:35pm</p>	F 241		
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F 241	Continued From page 12 revealed the DON had received complaints about call lights taking too long to answer, but there currently was no tool to resolve the concern. The DON continued to say they try to tell the nurses on each shift and remind them to be more aware of the residents needs. The DON stated she had not followed up with individuals who complained, about long delays for assistance.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to provide ongoing activities for two (2) of twenty-seven (27) sampled residents, (Residents #4 and #8). Resident #4 had two weeks during June and the month of July 2010 where no activities for the resident was documented. Resident #8 was not offered one to one activities consistent with know preferences.  The findings include:  Observations of Resident #4 on 09/21/10 at 10:00am, 10:56am 1:56pm, and 2:30pm revealed Resident #4 lying in a position with the head slightly elevated.  Observations of Resident #4 on 09/22/10 at 8:30am, 9:00am, 10:00am, and 11:55am	F 248 F 248	Resident # 4's activity sheet for October 2010 has been reviewed by the Administrator and Activity Director and indicates that 1:1 activities have been provided.  Resident # 8's activity sheet for October 2010 has been reviewed by the Administrator and Activity Director and indicates that 1:1 activities have been provided within resident # 8's assessed interests.  All residents assessed as requiring 1:1 activities activity sheet will be reviewed for completeness and to verify that the 1:1 activities are within the residents assessed interest by 10-22-10 by the Activity Director. Any concerns identified during the audit will be immediately addressed as appropriate.  A minimum random sampling of 10 residents assessed as requiring 1:1 activities will be reviewed by the Activity Director for completeness and to verify that the 1:1 activities are within the residents assessed interest quarterly.	10-26-10

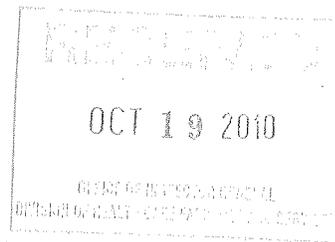
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F 248	<p>Continued From page 13 revealed Resident #4 in a Jerl chair.</p> <p>Review of the medical record for Resident #4 revealed the resident was admitted 01/27/10 with diagnoses of Oncomycosis (dry skin), Congestive Heart Failure, Hard of Hearing, Heart Failure, Senile Depression, Benign Prostrate Hypertrophy, Urinary Retention, Gout, Arthritis, Pacemaker, Peripheral Vascular Disease, Prostrate Cancer, Urinary Trach Infection, and Type II Diabetes. The care plan identified one to one (1:1) activities. The June activity log revealed an attempt on 06/03/10 when Resident #4 was asleep and no further documentation until 06/19/10. The activity log for the month of July 2010 was blank.</p> <p>An Interview on 09/23/10 at 1:30pm with the Activity Director revealed, when the director reviewed the chart, there was no documentation for July 2010. The chart contained a blank activity sheet for July. The director then reviewed the records maintained by the activly staff and there was no documentation for July 2010.</p> <p>Observations from 09/21/10 thru 09/24/10 Resident #8 self propelled throughout the facility non purposefully without involvement in 1:1 activities. Observation on 09/22/10 from 10:40am to 11:10am revealed the resident sitting at the back end of the 500 hallway looking outside alone.</p> <p>Record review for the month of July 2010 revealed, out of thirty-one (31) days, Resident #8 was involved in six (6) days of 1:1 activities, two (2) days of which involved outside.</p> <p>Record review for the month of August 2010 revealed, out of thirty-one (31) days, Resident #8</p>	F 248	The results of the audits will be reviewed by the QA Committee quarterly.	



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F 248	Continued From page 14 was involved in eight (8) days of 1:1 activities, only one (1) day involved outside.  Review of the Initial Activity Profile for Resident #8 dated 08/04/09 revealed the resident needed assistance for purposeful locomotion, liked outdoors and liked books with animals. However, observations during the survey revealed Resident #8 was not involved in 1:1 activities offered by the facility.  Interview at 11:40am on 09/24/10 with the Activities Director revealed that 1:1 activities are offered every day and are logged on the Resident 1:1 Activities/Visits and Independent Activities.  Interview at 11:50am on 09/24/10 with Asst. for Activities revealed no activities for Resident #8 had been identified from 09/21/10 until 09/23/10. She/He further stated that the weather had been appropriate for outside 1:1 activities for Resident #8.	F 248		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279 Resident #23 is no longer a resident at the facility.  Resident #13's wound assessment was completed and treatment was initiated. Resident #13's care plan has been revised to reflect wound status and interventions.  Resident #10's care plan has been updated to include current vision and cognitive deficits.	10-26-10

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F 279	<p>Continued From page 15</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a comprehensive care plan or revise a comprehensive care plan for three (3) of twenty-seven (27) sampled residents. The facility failed to develop and implement effective interventions to prevent accidents for Resident #23 when he/she complained of left knee pain on 03/01/10 after his/her left leg got caught under the wheelchair during staff transport. On 03/12/10, Resident #23 sustained a fracture of the left femur when his/her left leg got caught under the wheelchair while facility staff transported the resident. The facility failed to update the skin problems care plan for Resident #13. The facility failed to develop a vision and cognition care plan for Resident #10.</p> <p>The findings include:</p> <p>Review of the facility policy for Care Plan Process, dated 04/10/2008, revealed the Care Plan uses the assessment to develop, review, and revise the resident's comprehensive plan of care and the care plan is reviewed and revised as the resident's status changes.</p> <p>1. Review of the closed medical record for Resident #23 revealed the resident was admitted</p>	F 279	<p>The DON/ADON and Unit Managers will review all wound care plans by 10-22-10 to ensure accuracy and that interventions are on the nurse aide care plan.</p> <p>Social Services Department will audit all vision and cognitive care plans by 10-22-10 to ensure accuracy and that accommodations are on the nurse aide care plan.</p> <p>Unit Managers will audit wound care plans on all residents with skin issues weekly. Social Services Department will audit new admissions weekly to ensure accurate care plans.</p> <p>DON/ADON will meet with Unit Managers weekly to review wound care plan audits and Social Services Department to review vision and cognitive care plan audits. Results will be reported to the QA Committee quarterly.</p> <p>The facility will utilize the chart audit for skin and wound as well as vision and cognition quarterly for QA to ensure interventions are included appropriately on the care plan. The results of these audits will be reported to the QA Committee.</p>		



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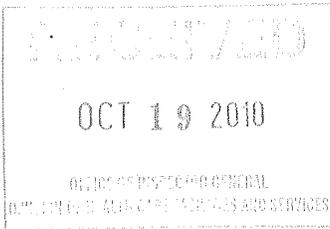
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F 279	<p>Continued From page 16</p> <p>on 02/09/10 with the diagnoses Heart Valve Replacement, Old Myocardial Infarction, Congestive Heart Failure, History of left knee replacement, and rehab. Review of the 02/16/10 Admissson Minimum Data Set (MDS) assessment for Resident #23 revealed the facility assessed the resident as independent with cognition, requiring two person extensive physical assist with bed mobility, requiring supervision and one person assist with ambulation and no limitation with range of motion. Review of the Resident Assessment Protocol Summary (RAPS) dated 02/16/10 for ADL functional/Rehabilitation potential revealed Resident #23 used a wheelchair for long distance as the resident "tires" easily. Review of the Falls summary revealed the facility documented that they would not care plan falls because the resident had not fallen at home, or since the resident arrived. It further detailed that Resident #23 was alert, oriented and able to make his/her needs known. Resident #23 was care planned for ADL Functional, Rehabilitation because he/she needed extensive assistance with bed mobility and transfers. The RAP summary indicated Resident #23 used a wheelchair for long distance as the resident "tires" easily.</p> <p>The Comprehensive Care Plan initiated on 02/17/10 stated the problem/need "requires assist with all ADL's, ranging from limited to total assist". The goal stated will be neat, clean, and well groomed through the next evaluation. Goal Date: 05/10. Interventions were detailed as: 1) set up supplies for am and pm cares and assist as needed. 2) remind to call for assist with all transfers, 3) transfer with assist of 1, 4) PT (Physical Therapy) and OT (Occupational Therapy) as ordered, 5) allow choices in care, 6)</p>	F 279		

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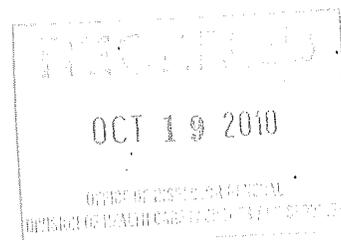
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NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 699 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 279	<p>Continued From page 17</p> <p>remind to use walker with transfer and ambulation.</p> <p>Review of the 03/02/10 Physical Therapy Notes revealed the "patient reports that the left foot got caught under the chair yesterday as it was being pushed and the left knee flexed beyond ninety degrees. Nursing reports patient has been cleared to continue physical therapy today. Patients left lower extremity exhibits pitiabile edema from foot to six inches above the knee. An interview with Physical Therapy Assistant (PTA), on 09/23/10 at 10:38am, revealed she documented the note on 03/02/10 that Resident #23 got the foot caught under the wheelchair the previous day. The PTA stated the resident told her that a male "aide" had pushed her the night before in the wheelchair and the resident got his/her left leg caught. On 03/02/10 Resident #23 complained of pain when the PTA got the resident up to ambulate. The PTA stated she retrieved the nurse that was providing care for the resident, the nurse assessed the resident and cleared the resident for Therapy.</p> <p>Interview with Registered Nurse #1 on 09/23/10 at 1:20pm revealed she was the nurse working on the 3-11 shift on 03/01/10 when Resident #23 had the first incident. She stated she didn't get any report of a possible injury to Resident #23. She stated Resident #23 had complained of pain and swelling of the left knee on the evening of 03/01/10 and that she assessed the leg for injury but didn't think anything was wrong. She stated she did not call the Physician because she didn't know of any incident/injury, and didn't think there was an injury. An interview with the Rehab Manager, on 09/22/10 at 9:15am, revealed she did recall a previous incident in which Resident</p>	F 279		



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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2010
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 279	Continued From page 18 #23 was in a wheelchair being pushed by staff, and the left leg dropped down, but she did not recall that it caused an injury. Interviews with Licensed Practical Nurse #5 (assigned to Resident #23 on 03/01/10), on 09/24/10 at 10:30am, with LPN #4, on 09/24/10 at 10:00am, and with the Director of Nursing (DON), on 09/24/10 at 11:30am, revealed they had no knowledge of the 03/01/10 incident where Resident #23 got his/her foot caught under the wheelchair. Furthermore, there was no evidence that the facility investigated to identify the causal factors of the resident's complaint of pain to the knee or the swelling which was noted by RN#1 on 03/01/10. Additionally, there is no evidence that the facility developed or implemented care plan interventions to prevent the recurrence of the resident's foot getting caught under the wheelchair. Further review of the Comprehensive Care Plan revealed the facility revised the care plan on 03/05/10 to include the following intervention: Bed alarm to bed to alert staff; however, there was no evidence that the facility revised the care plan to reflect an intervention to address the resident getting his/her leg caught under the wheelchair while being transported by staff.  Review of the nurses notes, dated 03/12/10 at 12:45pm, revealed Resident #23 was being wheeled up the hallway by the Therapy Tech #2. The resident's left leg drug under the wheelchair. Both the resident and the Therapy Tech heard a pop sound from the left knee. Facility staff placed Resident #23 in bed and applied ice to the knee. Resident #23 was sent to the hospital for an x-ray of the left knee. The x-ray confirmed the fracture of the left femur.	F 279		



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NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 279	<p>Continued From page 19</p> <p>Further review of the Comprehensive Care Plan revealed on 03/13/10 the facility revised the care plan with the following interventions: transfer with sheet lift with 4 or 5 assist; PT and OT were then put on hold. However, further review revealed no evidence the facility developed interventions to address the resident getting his/her leg caught under the wheelchair while being transported by staff.</p> <p>An interview with the Director of Nursing (DON), on 09/24/10 at 11:30am, revealed the Comprehensive Care Plans are initiated by the staff who complete the Minimum Data Set (MDS) assessment, but the nurses on the units are to add any updates to the care plans as the resident's status changed. The DON stated she did not know of a previous report of injury that occurred prior to the fracture sustained by Resident #23.</p> <p>2. Review of Resident #13's care plan revealed "skin problem" with goal dates of 08/08/10 and 08/13/10 for wound improvement and resolution. An intervention for Granulex soak for 14 days was dated 08/25/10. No further intervention or updates were available for review on 09/22/10.</p> <p>On 09/23/10 at 9:40am, observation of Resident #13's left heel wound care and assessment, performed by LPN #2, revealed an open wound described as pink tissue and having no drainage. Granulex soak treatment was provided to the area.</p> <p>Interview with LPN #3 and the Director of Nursing (DON), on 09/24/10 at 11:00am, revealed on 09/22/10 the DON was consulted regarding the heel wound of Resident #13. The DON stated she removed a small piece of dried skin covering</p>	F 279		

OCT 19 2010

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