

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

PRINTED: 02/19/2014
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 01/30/2014
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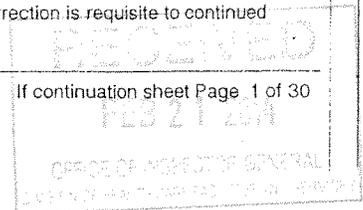
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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F 000	INITIAL COMMENTS Amended 02/19/14 A standard health survey was initiated on 01/28/14 and concluded on 01/30/14 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 01/28/14 with no deficiencies cited.	F 000		
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and review of the resident's trust fund account documentation, it was determined the facility failed to convey funds from the resident trust fund accounts in a timely manner upon the death of four (4) of four (4) unsampled residents (Unsampled Residents A, B, C, and D): The findings include: The facility failed to provide a specific policy regarding conveyance of funds after a resident's death. 1. Review of Unsampled Resident A's Trust	F 160	F160 Un-sampled residents A,B,C and D's trust accounts have all been refunded and accounts closed out at the present time. Bookkeeper and Assistant Bookkeeper and Assistant Administrator will complete and audit all residents that have discharged or expired. This audit will ensure that all refunds of the resident's trust account have been refunded to the resident if they are discharged home, or to "the estate of the particular resident" if they have expired within 30 days of the discharge date or expired date. If necessary, refunds will be sent back to the Social Security office if appropriate. All discharged residents or expired residents accounts will then be closed. This audit will be performed twice a month for three months then monthly for 9 months by Bookkeeper or Assistant Bookkeeper. The findings will be reported to the QA Committee by the Bookkeeper no less than Quarterly for one year.	3/11/14 Completion Date: 03/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X Administrator	DATE 03/11/14
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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 160

Continued From page 1

Account revealed the resident had deceased on 10/10/13; however, the facility failed to convey funds to the responsible party until 01/15/14, 97 days after the resident expired.

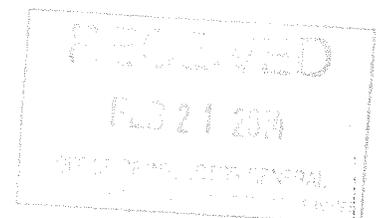
2. Review of Unsampled Resident B's Trust Account, revealed the resident expired on 06/04/13; however, the funds were not dispensed until 07/08/13, 34 days after the resident expired.

3. Review of Unsampled Resident C's Trust Account, revealed the resident expired on 06/03/13; however, the resident's trust account was not dispensed until 07/08/13, 35 days after the resident expired.

4. Review of Unsampled Resident D's Trust Account, revealed the resident expired on 07/18/13; however, the trust account was not conveyed until 08/19/13, 32 days after the resident expired.

Interview with the accountant who was responsible for reconciling the trust fund accounts, on 01/29/14 at 11:01 AM, revealed she knew resident trust fund accounts were to be closed within 30 days of a resident's death; however, she stated there were was a specific reason Unsampled A's account was closed so late. She stated the local coroner called the facility and requested the money not be conveyed to the resident's estate, but to be forward to the local funeral home for burial expenses. She stated the administrator received the phone call and directed her to hold the funds until it could be released to the funeral home. That process took place this month. She indicated the resident's family did inquire about the money in the trust fund but she told them it would be going to pay

F 160



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F 160 Continued From page 2 the funeral home bills.

In addition, the accountant revealed she would wait and convey funds after receiving the monthly bank statement. She would review the statement to see if any resident had expired. She would then convey the funds if any was due. She revealed she had not closed out Unsampled B, C, and D's accounts when the residents expired even though the accounts had zero balance. She waited for the next month's bank statement and paid out interest if any was due.

F 160

Interview with the Administrator, on 01/29/14 at 11:20 AM, revealed he received a call from the coroner's office requesting the resident's funds be sent to the local funeral home for burial expenses. He stated he directed the accountant not to give the money to the resident's family. He had been told by the coroner the family would not pay the funeral home bill. He indicated he thought it would be okay to convey the money to the funeral home for burial expenses. When asked if the funeral home or coroner had legal authority over the resident's account, the Administrator did not know and could not provide written proof. He stated normally, the trust account should be closed and money conveyed within thirty (30) days after the resident had expired.

F 221 483.13(a) RIGHT TO BE FREE FROM
SS=E PHYSICAL RESTRAINTS

F 221

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

F 221
1. Residents 8,9,12,15, and 16 were identified to be residents that were determined to have failed attempts at restraint reduction. Residents 8,9,12,15, and 16 will be discussed in length at next restraint meeting by DON, ADON, MDS, and Unit Manager by 02/28/2014. Appropriate form will be completed by the committee at the time of meeting and any trial reduction will

Completion Date:
02/28/2014

3-15-14
m. D. ...
by PB
2-24-14



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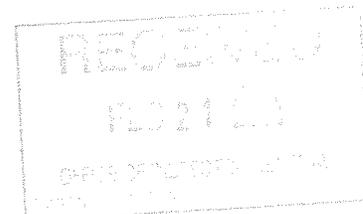
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F 221	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and policy review, it was determined the facility failed to attempt restraint reductions for five (5) of twenty-four (24) sampled residents, Resident #8, #9, #12, #15 and #16.</p> <p>The findings include:</p> <p>Review of the Restraint Policy, effective 2009, revealed the purpose was to establish a systematic process for the assessment of implementation of use of and evaluation of the use of a physical restraint. If a device was determined to be a restraint, the facility would ensure that the least restrictive device was used for the least amount of time. The facility would periodically re-evaluate the use of the restraint to determine if reduction of use was appropriate.</p> <p>1. Observations of Resident #12, on 01/28/14 at 2:35 PM, 3:27 PM and 4:11 PM, revealed Resident #12 sitting in a wheelchair with his/her lap buddy on with no behaviors of trying to come out of wheelchair. Observation of Resident #12, on 01/29/14 at 8:30 AM and 9:31 AM, revealed Resident #12 sitting in wheelchair with his/her lap buddy on with no behaviors of trying to come out of wheelchair. Observation of Resident #12, on 01/30/14 at 7:50 AM, revealed Resident #12 sitting in a wheelchair with his/her lap buddy on with no behaviors or trying to exit the wheelchair.</p> <p>Observation of Resident #12, on 01/29/14 at 2:50 PM and 01/30/14 at 9:55 AM, revealed Resident #12 leaning forward while in the wheelchair with his/her lap buddy on.</p>	F 221	<p>Be initiated by the licensed nursing staff assigned to resident if found to be needed.</p> <p>2. All residents with a restraint will be discussed and care plan reviewed by DON, ADON, Staff Development nurse, MDS and Unit Manager at next monthly meeting to be held by 02/28/2014. Any trial reductions will be initiated if found to be appropriate after the meeting and be implemented by any licensed staff member work with that resident. The form will be completed at the time of the meeting by the committee. Family and MD will be notified by the Unit Manager or Assistant Unit Manager of any changes being made.</p> <p>3. Licensed staff will be educated on the restraint Policy by 03/31/2014 by Staff Development Coordinator or Unit Manager and then annually thereafter by Staff Development Coordinator. This education will also be presented to newly hired staff by the Staff Development Coordinator and be ongoing. An audit of all restraints will be done by Unit Manager or ADON and attempts to reduce restraints will be completed by ADON or Unit Manager on all residents with a restraint monthly for three months to begin in February 2014. After three months, at least 5 residents will be audited for nine months by DON, ADON or Unit Managers.</p> <p>4. The DON, ADON, MDS, and Unit Manager will participate in monthly restraint</p>	<p>Completion Date: 02/28/2014</p>
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F 221	<p>Continued From page 4</p> <p>Review of Resident #12's record, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease, Dementia with Behavior and Seizure Disorder.</p> <p>Review of Resident #12's Minimum Data Set (MDS) Annual Assessment, dated 04/25/13, revealed the facility triggered Resident #12 for restraints and was assessed with a BIM score of 3 which meant Resident #12 was not interviewable. Review of Resident #12's MDS Quarterly Assessment, dated 01/15/14, revealed the facility triggered Resident #12 for restraints and assessed the resident with a BIM score of 3 which meant Resident #12 was not interviewable.</p> <p>Review of Resident #12's Restorative Detail Report, dated 01/01/14 through 01/28/14, revealed Resident #12 had not declined in Activities of Daily Living, but was able to do fifteen minutes of active range of motion for fifteen (15) minutes and was able to tolerate the activity well.</p> <p>Review of Resident #12's Restraint Review, completed 12/30/13, revealed the restraint being reviewed was a lap buddy to the wheelchair (w/c) and the medical symptom being treated was an unsteady gait. The Restraint Review form revealed, an answer of "no" to question, had the resident had a decline in any areas such as cognition, mood/behavior, motor function/activities of daily living (ADL), continence, skin, activities or overall change in status. The Restraint Review form, revealed an answer of "yes" to the question, had the restraint remained effective and met its intended purpose. The purpose was stated as no ADL decline. The Restraint Review form, revealed an answer of "no" to the question, had there been a change in</p>	F 221	<p>Meeting for twelve months. Audit will be completed on residents and reduction attempts on all residents for three months and then 5 residents for nine months by DON, ADON, or Unit Manager. All findings will be presented to the QA Committee no less than quarterly for one year by DON.</p>	<p>Completion Date: 02/28/2014</p>
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F 221	<p>Continued From page 5</p> <p>medical symptom being treated by the device and an answer of "yes" to the question, was the restraint the least restrictive device to treat the resident. This form was signed by the Interdisciplinary Team.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 01/30/14 at 1:48 PM, revealed she could not remember staff doing a trial reduction on Resident #12. CNA #5 stated she new Resident #12 had some falls, but could not remember the last time Resident #12 had an actual fall. Resident #12 could propel him/herself in a w/c and had not declined that she was aware of.</p> <p>Interview with Restorative Aid #1, on 01/30/14 at 1:53 PM, revealed Resident #12 walked pretty well with the Restorative Aid everyday and had not changed in his/her ADL's and could propel him/herself in his/her w/c. CNA #5 stated she had not seen Resident #12 attempt to exit his/her wheelchair.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/30/14 at 2:00 PM, revealed she floated to different units. LPN #1 stated she had not witnessed Resident #12 with any seizure or fall activity that she was aware of.</p> <p>Interview with Assistant East Unit Manager, on 01/30/14 at 10:34 AM, revealed before they considered a resident for restraints, the facility first refered them to therapy and to see if the resident could improve. Then they tried to utilize chair alarms and anti-tippers to the wheelchair. If therapy said they have done all they could do, then the nursing staff would then complete a restraint assessment and have the family fill out a Restraint Information for Resident and Family</p>	F 221		

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F 221

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form. They would complete a Decision Tree form and then review the restraint monthly. The Assistant East Unit Manager stated she usually did not attend the restraint meetings, it was usually the Unit Manager. The Assistant East Unit Manager did attend the restraint meeting held on 12/30/13 . The Assistant East Unit Manager, stated during the restraint meeting the staff would check to ensure the CNA's were releasing the restraint as ordered and that the staff were in agreement with the use of the restraint. The Assistant East Unit Manager stated the group talked about reductions quarterly. She said when a trial reduction was performed they kept a one to one (1:1) staff member with the resident at all times and continued to monitor for falls. This information would be documented in the nurses notes.

Review of Resident #12's nurses notes revealed there was no documentation of a restraint trial reduction completed with in the last year.

Further Interview with the Assistant East Unit Manager, revealed Resident #12 had not had any trial restraint reductions completed. The Assistant East Unit Manager stated she was not sure of what the policy had to say about reductions. She stated she was aware Resident #12 was in restraints because the resident had some seizure activity and falls.

Review of Resident #12's Nurses Notes, dated 02/11/13, revealed Resident #12 had two (2) seizures in one day in which the resident had to be administered Ativan 2 mg. Review of Resident #12's Nursing Notes, dated 04/08/13, revealed the resident had a twitching episode that was assessed by the Nurse Practioner as a seizure.

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Interview with the Director of Nursing (DON), on 01/30/14 at 3:00 PM revealed Resident #12 had a fall in September of 2013, which was the last documented fall in which the resident removed his/her lap buddy and fell out of the w/c.

Interview with the Assessment Nurse, on 01/30/14 at 3:50 PM, revealed she had been in that role for six (6) months and she did attend the December meeting. The Assessment Nurse stated during the meetings the staff would talk about reductions of restraints. The Assessment Nurse stated a reduction was not completed on Resident #12 because his/her family member did not want one completed. The Assessment Nurse stated when she read the Restraint Policy which said the least amount of time, she felt that meant the shortest amount of time the restraint would be utilized.

Further interview with the DON, on 01/30/14 at 1:00 PM, revealed Resident #12 was initially put in a restraint for positioning and then the resident sustained a fall in which he/she had hit his/her head and sustained some abrasions with no fracture. The DON stated Resident #12's family wanted the lap buddy because he/she felt the resident would be safe and it would prevent injuries. The DON stated Resident #12 was able to propel his/herself throughout the facility, but was not interviewable. The DON stated her and staff met weekly for falls and monthly for restraints. When they met for the restraint meeting; the group would look at what was the least restrictive for each resident and that the Assessment Nurse was responsible for monitoring restraints. The DON stated the facility did not have a policy on reductions.

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F 221	<p>Continued From page 8</p> <p>2. Review of the medical record for Resident #8 revealed the facility admitted the resident on 01/18/12 with diagnoses of Dementia, History of Transient Ischemic Attack, and Diabetes. Review of the Restraint Assessment, completed on 07/10/13, revealed the facility placed a Lap Buddy restraint to the wheel chair for medical symptoms related to decreased safety awareness.</p> <p>Review of the Restraint Review for Resident #8, dated 08/23/13, 09/30/13, 10/30/13, 11/17/13, and 12/30/13, revealed under the section, what reduction efforts have been attempted or considered since last review, each one stated, released during meals, activities, and with toileting per toileting program. There was no evidence the facility made any attempt to reduce the restraint use or type.</p> <p>Observation, on 01/30/14 at 9:30 AM, revealed Resident #8 sitting up in the wheel chair in the television lounge area. The lap buddy was in place to the wheel chair and the resident was leaning over the lap buddy with hand on head dozing.</p> <p>Observation, on 01/30/14 at 10:29 AM, revealed Resident #8 was rolled over to the table, by staff, with six (6) other residents for a Bible reading activity. The lap buddy was not removed.</p> <p>Continued observation, on 01/30/14 at 10:56 AM, and 11:38 AM, revealed Resident #8 remained at the bible study activity with the lap buddy left in place. At 12:15 PM the Activities Assistant (AA) asked the resident if he/she would like to stay where they were or go to the dining room. The</p>	F 221		

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F 221	<p>Continued From page 9</p> <p>resident responded "it don't matter". The AA rolled the resident into the resident dining area. The lap buddy restraint was never removed.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed it included daily restraint when up in w/c, lap buddy in place. The goal stated the resident would have a least restrictive restraint daily thru next evaluation with three (3) approaches: Restraint assessment monthly, Remove lap buddy at meal time and reposition at least every 2 (two) hours.</p> <p>Review of the Minimum Data Set Quarterly Assessment, dated 10/08/13, and the Annual Assessment, completed 01/01/14, revealed no change in transfers that required extensive assistance with one (1) staff, ambulation occurred once or twice with one (1) person physical assist, and no impairment with Range of Motion with upper and lower extremities.</p> <p>Review of Restorative summaries for January 2014 revealed Resident #8 remained the same in ambulation of one hundred (100) feet to one hundred forty (140) feet daily throughout the month.</p> <p>Interview with the Activities Assistant (AA), on 01/30/14 at 1:30 PM, revealed she did recall that at one time activities would take restraints off including lap buddies, and seat belts while residents were in activities. She stated she did not always do that with Resident #8 because the resident very seldom stayed in the activity the entire time. She stated she was not sure if removing the restraints during an activity was still in affect. She stated she probably did not document in the record of Resident #8 the reason</p>	F 221		

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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 01/30/2014
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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 221	<p>Continued From page 10</p> <p>she had not removed the restraint. She stated the purpose of removing the restraint in an activity was because the resident was generally under direct supervision and it would be a good practice to release them.</p> <p>3. Review of the medical record for Resident #16 revealed the facility admitted the resident on 08/04/12 with diagnoses including Alzheimer's Dementia with Disturbance in Mood, and Impulse Control Disorder.</p> <p>Review of the Minimum Data Set Annual Assessment, dated 08/08/13, for Resident #16 revealed the facility assessed the resident's Basic Interview for Mental Status (BIMS) score at a 12, moderately impaired. The facility completed a Quarterly Assessment on 01/24/14 and assessed the residents BIMS sore at an 11 moderately impaired.</p> <p>Review of the Care Plan for Resident #16 revealed a care plan was developed for Restraints on 01/13/14. The care plan consisted of a check list with lap buddy in w/c checked. The only risk factor checked or written was a decline in mobility related to the lap buddy in the wheelchair. The goal was to show no signs and symptoms of decline. Interventions for the restraint care plan included Restorative Program checked with no description of what would be provided, pressure relieving device checked with no description of what device or when it would be provided and a turning schedule checked with no description of when this would be provided. There was no intervention on the comprehensive care plan to lay resident down between meals. Review of the Nursing Assistant sheet revealed it did not indicate to lay resident down between</p>	F 221		

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F 221	<p>Continued From page 11 meals.</p> <p>Review of the Restraint Assessment, dated 01/13/14, revealed the facility placed the lap buddy due to decreased safety awareness. Number 5 on the restraint assessment stated interventions attempted to treat the medical symptoms prior to the use of the restraint with the response listed as repositioning. Under the section motor function posture documentation, it stated while sitting resident leans forward at all times. Review of a falls investigation dated 01/13/14 revealed the resident had a fall out of the wheelchair at 11:45 AM. The resident had a bruise and laceration to the forehead.</p> <p>Review of Physician orders revealed Physical Therapy was ordered on 01/15/14 due to a recent fall. The assessment summary impression from the physical therapy evaluation revealed Resident #16 was positioned well in the wheelchair with no leaning evident; however, nursing reported frequent leaning laterally and anteriorly. Nursing was informed of the evaluation and nursing reported the patient sometimes falls asleep in the wheelchair and did not have a scheduled nap during the day. Therapy recommended laying the resident down throughout the day to see if it helped with positioning due to the fact leaning and falls might be due to fatigue from sitting in the wheelchair for long periods of time. Continued review of the Physician orders for Resident #16 revealed, on 11/10/13 an order was received for a bed alarm, chair alarm and lap buddy. An order was received on 11/11/13 to discontinue the lap buddy restraint.</p> <p>Continued review of the care plan revealed there was no intervention on the comprehensive care</p>	F 221		

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F 221	<p>Continued From page 12</p> <p>plan to lay the resident down between meals. Review of the Nursing Assistant sheet revealed it did not indicate to lay the resident down between meals.</p> <p>Observation, on 01/30/14 at 9:30 AM, revealed Resident #16 was sitting in the TV lounge area watching TV. A lap buddy was in place to the wheelchair. The resident was alert and conversing with no evidence of leaning in the chair. The resident's speech was somewhat garbled and difficult to understand at times.</p> <p>Observation, on 01/30/14 at 10:19 AM, revealed Resident #16 sitting up in the wheelchair self propelling the chair. A lap buddy was in place. The AA invited the resident to attend Bible study.</p> <p>Observation, on 01/30/13 at 10:30 AM, revealed Resident #16 was in the Bible study activity with six (6) other residents. The resident tried to remove the lap buddy, but was unable.</p> <p>Observation, on 01/30/14 at 10:58 AM and 11:35 AM, revealed Resident #16 sitting up in the wheelchair in a Bible study activity. The lap buddy remained in place. There was no evidence of the resident leaning or falling over in the wheel chair.</p> <p>Interview with the Activities Assistant, on 01/30/14 at 1:30 PM, revealed she did recall that once upon a time activities would take restraints off including lap buddies, and seat belts while residents were in activities. She stated she was not sure if removing the restraints during an activity was still in affect. She stated the purpose of removing the restraints in an activities was because the resident was generally under direct</p>	F 221		

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F 221	<p>Continued From page 13 supervision and it would be a good opportunity to release them.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 01/30/14 at 1:40 PM, revealed she had provided care for Resident #8 and #16, revealed restraints should be released every two (2) hours and during activities. She stated so the resident did not have to be in the restraint any more than necessary. She stated the nurses and Managers do ask the CNA's their input when asking about restraints for residents.</p> <p>Interview with CNA #4, on 01/30/14 at 1:50 PM, revealed she had provided care for Resident #8 and #16. She stated restraints should be removed every two (2) hours and at meals. She stated she was not sure if restraints were removed for activities. She stated restraints were removed for comfort of the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 01/30/14 at 2:00 PM, revealed she would expect restraints to be removed at meals, activities, and every two (2) hours. She stated the role of the restraint reduction assessment has changed recently. She stated she did not complete them and was not necessarily asked about restraint reduction on her residents that had restraints. She stated restraints were generally used as a last resort and only if the cognition was to the point of not understanding safety awareness. She stated she had seen restraints discontinued but it had been awhile. She stated she was not sure if it was protocol for the Therapy Department to evaluated every resident after a fall, but they do attend weekly falls committee meetings. She stated she had not had a situation on her residents with restraints</p>	F 221		

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F 221	<p>Continued From page 14</p> <p>where the family was demanding the resident have restraints. She stated the potential complication for restraints were decreased mobility, skin breakdown and dignity.</p> <p>Interview with the West Unit Manager, on 01/30/14 at 2:08 PM, revealed she was not responsible for restraint assessments or documentation. She stated she attended weekly falls committee and monthly restraint meetings. She stated someone from each discipline attended the meetings. She stated in the time she had been there, two (2) residents had a reduction in restraints. She stated they have a problem with families complaining and wanting restraints. She stated restraints should be removed every two (2) hours, during meals, activities and situation where there was direct supervision. In regards to Resident #16 she stated they don't always consult Therapy after a fall. She stated they had discussed about laying Resident #16 down for naps. She stated she believed every resident with a lap buddy should be assisted to lay down between meals. She stated there needed to be some revisions for restraints.</p> <p>4. Observation of Resident #9, on 01/28/14 at 5:10 PM, revealed the resident self propels on the unit and in the halls. The wheelchair seatbelt was on and in use.</p> <p>Review of the medical record for Resident #9 revealed the facility admitted the resident on 10/12/11 with diagnosis including Vascular Dementia, Falls, Late Effect Cardiovascular Disease, Memory Loss, Diabetes Mellitus II and Hypertension. Review of the Device Decision</p>	F 221		

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Tree, dated 01/06/12 identified the wheelchair seatbelt alarm was placed as a restraint. A quarterly review of the facility's Device Decision Tree was completed on 01/02/13, 06/21/13 and on 12/11/13. The Review of the Restraint Assessment, completed on 01/06/12, revealed the facility placed a seat belt alarm to the wheel chair as a restraint for medical symptoms of an unsteady gait, a history of falls and a history of a Traumatic Subdural Hematoma. Review of the restraint information for the family, which listed potential benefits and risk of the wheelchair seatbelt restraint was last dated and signed by the resident's Power of Attorney (POA) on 01/09/12. Review of the facility's fall risk screen, dated 09/06/13 and 12/11/13 revealed the continued use of restraints.

Review of the Minimum Data Set Annual Assessment, dated 09/17/13, for Resident #9 revealed the facility assessed the residents Basic Interview for Mental Status (BIMS) score a two (2), severely impaired.

Review of the restraint care plan for Resident #9, onset dated as 01/06/12 and goals were dated for 01/2013, 06/2013, 9/2013, 12/2013 and 03/2014 included toileting schedule, scheduled release of the belt every two (2) hours, as needed and during meals. Additional interventions included therapy as ordered, pressure relieving device, and a cushion to the wheelchair.

5. Observation of Resident #15, on 01/29/14 at 4:30 PM, revealed the resident was in the sitting area near the nurses station with the lap tray on the wheelchair. Observation, on 01/30/14 at 9:10 AM revealed he/she was in the wheelchair with the lap tray in place. Observation, on 01/30/14 at

F 221

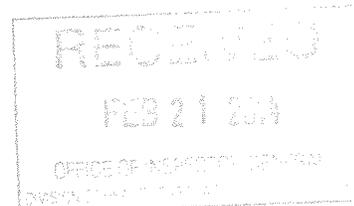
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F 221	<p>Continued From page 16</p> <p>9:40 AM, revealed the lap tray remained on wheelchair.</p> <p>Review of the medical record for Resident #15 revealed the facility admitted the resident on 06/28/12 and readmitted on 09/23/13 with diagnoses of Alzheimer's Disease, Dementia without Behavioral Disturbances, Tremors, Iron Deficiency Anemia, Anorexia, Failure to Thrive Adult and Epilepsy. Review of the Restraint Assessment and the Device Decision Tree, dated 08/01/12, identified the lap buddy on the wheelchair was assessed as a restraint. Review of the facility's restraint review for the lap buddy on the wheelchair, dated 07/03/13, 08/23/13, 09/30/13, 10/30/13, 11/27/13 and 12/30/13 revealed the reductive efforts attempted or considered since the last review were not identified; however, care planned interventions were listed as released at meals, during activities and when toileted. The explanation area was left blank in the section that questioned if this restraint was the least restrictive device to treat this resident.</p> <p>Review of the Minimum Data Set Annual Assessment, dated 06/12/13, for Resident #15 revealed the facility assessed the residents Basic Interview for Mental Status (BIMS) score a 2, severely impaired.</p> <p>Interview with the Assistant East Unit Manager, on 01/30/14 at 2:10 PM, revealed there was no evidence of an attempted restraint reduction for Resident #9 or Resident #15.</p>	F 221		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		



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F 253	<p>Continued From page 17.</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Maintenance work order logs, it was determined the facility failed to have an effective Maintenance Program to ensure the resident's environment was comfortable and safe. Observation during the environmental tour revealed splinted doors with chunks of wood missing on four (4) of six (6) halls, which involved 200, 300, 500 and 600 Hall.</p> <p>The findings include: The facility failed to provide a policy regarding maintenance of the building.</p> <p>Observation during the environmental tour with the Director of Maintenance, on 01/29/14 at 2:10 PM through 2:30 PM, revealed multiple interior doors leading to residents' rooms were splintered with chunks of wood missing. The surface of the doors was very rough to touch. These areas were wheelchair height and exposed to residents, staff, and visitors.</p> <p>Observation of the 200 Hall revealed the interior doors to Rooms 206, 207, 208, 209, and 213 had chipped wood with large areas where chunks of wood was missing leaving rough raw wood exposed with splinters. Observation of the 300 Hall revealed Rooms 300 and 306 were the same. The 500 Hall revealed Rooms 505, 506, 510, and</p>	F 253	<p>F 253 Rooms identified in the SOD; 206, 207, 208, 209, 213, 300, 306, 505, 506, 510, 513, 605, 608, and 611 were corrected immediately. The nicks, chips, and splinters in the doors were sanded and the chipped wood was filled in. All other doors leading into patient rooms have been audited for splinters, chips, and roughness and have been filled, sanded, and repaired. All rooms will be audited monthly for six months then quarterly after that by the Maintenance Assistant. Audits will consist of Maintenance Assistant checking all wood doors to ensure smooth surfaces with no exposed splinters and that all holes are filled in and sanded. Maintenance Supervisor will ensure that these audits are done timely and keep these findings on a preventative maintenance log. These findings will be reported to the QA Committee by Maintenance Supervisor on a Quarterly Basis.</p>	Completion Date: 03/11/14

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F 253	<p>Continued From page 17.</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the Maintenance work order logs, it was determined the facility failed to have an effective Maintenance Program to ensure the resident's environment was comfortable and safe. Observation during the environmental tour revealed splinted doors with chunks of wood missing on four (4) of six (6) halls, which involved 200, 300, 500 and 600 Hall.</p> <p>The findings include:</p> <p>The facility failed to provide a policy regarding maintenance of the building.</p> <p>Observation during the environmental tour with the Director of Maintenance, on 01/29/14 at 2:10 PM through 2:30 PM, revealed multiple interior doors leading to residents' rooms were splintered with chunks of wood missing. The surface of the doors was very rough to touch. These areas were wheelchair height and exposed to residents, staff, and visitors.</p> <p>Observation of the 200 Hall revealed the interior doors to Rooms 206, 207, 208, 209, and 213 had chipped wood with large areas where chunks of wood was missing leaving rough raw wood exposed with splinters. Observation of the 300 Hall revealed Rooms 300 and 306 were the same.</p> <p>The 500 Hall revealed Rooms 505, 506, 510, and</p>	F 253	<p>F 253</p> <p>Rooms identified in the SOD; 206, 207, 208, 209, 213, 300, 306, 513, 605, 608, and 611 were corrected immediately. The nicks, chips, and splinters in the doors were sanded and the chipped wood was filled in. All other doors leading into patient rooms have been audited for splinters, chips, and roughness and have been filled, sanded, and repaired. All rooms will be audited monthly for six months then quarterly after that by the Maintenance Assistant. Audits will consist of Maintenance Assistant checking all wood doors to ensure smooth surfaces with no exposed splinters and that all holes are filled in and sanded. Maintenance Supervisor will ensure that these audits are done timely and keep these findings on a preventative maintenance log. These findings will be reported to the QA Committee by Maintenance Supervisor on a Quarterly Basis.</p>	<p>Completion Date: 03/11/14</p>

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F 253	Continued From page 18 513 had wood missing with splintered roughness. Interview with the Director of Maintenance, on 01/29/14 at 2:45 PM, revealed his department did walking rounds throughout the facility each morning to check for environmental issues that could be a safety problem for the residents. He stated his workers had been patching the wood interior doors leading to residents' rooms, but they may have missed some. He stated he relied on nursing and housekeeping staff to inform him of any problems that needed immediate attention. He did not have a routine repair schedule for the residents' wooden doors. They fixed them whenever someone reported a problem or when the Maintenance Department noticed the need for repair during the morning rounds. Continued observation of the environment at 4:15 PM revealed Rooms 605, 608, and 611 had chunks of wood missing with splinters exposed. Room 605 had a very large (3 inch) splintered piece of wood sticking out from the right side of the interior door leading into the resident's room. Interview with the resident (in the presence of the West Unit Manager), on 01/29/14 at 4:45 PM, revealed the door was damaged on Monday night (01/27/14) when staff hit the door with the shower bed. The resident stated staff knew about the damaged door, but nobody had inquired about the door until the surveyor asked about it. Interview with the West Unit Manager, during the resident's interview, revealed she had no prior knowledge of the damaged door. She stated the staff that had damaged the door should have reported the incident and placed a request for repair on the Maintenance work order log. She indicated the door could be a hazard to residents	F 253		

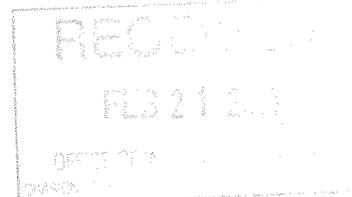
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F 253	Continued From page 19 as they could get hurt from the protruding sharp wood. Review of the maintenance work order log for the month of January revealed no documentation regarding damage to the interior door in Room 605 or any other doors in the facility. Interview with the Maintenance Director, on 01/29/14 at 5:00 PM, revealed he was unaware of the damage to Room 605.	F 253		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	F 280 1. Residents 8, 9, 10, 12, and 16 were identified to be residents that had care plans that were not individualized and complete. Care Plans will be reviewed by DON, ADON, MDS, and Unit managers by 02/28/2014. Corrections will be made and residents 8, 9, 10, 12, and 16 will be discussed at next monthly restraint meeting to be held by 02/28/2014. 2. A care plan audit of all residents with restraints will be conducted to ensure that all care plans are correct and individualized by DON, ADON, MDS, and Unit manager by 02/28/2014. Care Plans will be corrected if found to be deficient. 3. Licensed staff will be educated by DON, ADON, Staff Development Coordinator, MDS, and Unit Manager on writing specific goals and interventions on care plans that	Completion Date: 02/28/2014



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PRINTED: 02/19/2014
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 01/30/2014
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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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(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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Continued From page 20

Based on observation, interview, record review and policy review, it was determined the facility failed to revise care plans for five (5) of twenty-four (24) sampled residents, Residents #8, #9, #10, #12 and #16 restraint care plans were not individualized.

The finding include:

Review of the Care Plan Policy, no date provided, revealed the resident care plan process assured quality resident care through the coordination of each discipline's expertise. Each discipline assesses the resident noting facts and observations. The RAI process would be utilized to determine resident care needs. Goals should be stated to include what would be accomplished; when would it be accomplished; and how the goal would be measured.

1. Review of Resident #12's record revealed the facility admitted the resident with diagnoses of Alzheimer's Disease, Dementia with Behavior and Seizure Disorder.

Observations of Resident #12, on 01/28/14 at 2:35 PM, 3:27 PM and 4:11 PM, on 01/29/14 at 8:30 AM and 9:31 AM, and on 01/30/14 at 7:50 AM, revealed Resident #12 was sitting in a wheelchair with his/her lap buddy on with no behaviors or trying to exit the wheelchair.

Review of Resident #12's Restraint Care Plan, dated 02/28/12, revealed the problem identified was the lap buddy in the wheelchair (w/c), but no risk factors were identified, such as accidental injury, constipation, pressure sores, decline in mobility, increased agitation, symptoms of

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Are individualized and complete by 03/05/2014. This education will also be presented to newly hired staff by Staff Development Coordinator during orientation and be ongoing. All Care Plans will continue to be reviewed by DON, ADON, MDS, staff nurses, and Unit Manager monthly for three months at restraint meeting to begin in February 2014 for accuracy and individualization. After three months, at least 5 care plans will be reviewed for nine months by DON, ADON, or Unit Manager.

4. The DON, ADON, MDS, and/or Unit Manager will review all care plans involving restraints at least monthly for three months and then at least 5 a month for nine months. All Findings will be presented to the QA Committee no less than quarterly for once year by DON.

Completion Date:

02/28/2014

3-6-14

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F 280	<p>Continued From page 21</p> <p>withdrawal, depression or reduction of independence. The Restraint Care Plan revealed one (1) goal; Resident #12 would not show signs or symptoms of decline. No other goals were identified, such as, using the least restrictive measure, time frame for when resident would be free of restraint or goal of a restraint reduction. Interventions revealed a daily restorative program, therapy as ordered, turning every two (2) hours and as needed and routine incontinent care. There were no interventions identified as the removal of the restraint at meals and/or during activities.</p> <p>Interview with the Director of Nursing (DON), on 01/30/14 on 3:00 PM, revealed the risk factors on the care plan should have been marked and who ever initiated the Restraint Care Plan should have marked the risk factors. The DON stated Resident #12's care plan could be more personalized, such as reductions and utilizing the least restrictive and giving appropriate time tables for completing the tasks.</p> <p>2. Review of the medical record for Resident #8 revealed the facility admitted the resident on 01/18/12 with diagnoses including Dementia, History of Transient Ischemic Attack, and Diabetes. Review of the Restraint Assessment, completed on 07/10/13, revealed the facility placed a lap buddy restraint on the wheel chair for medical symptoms related to decreased safety awareness.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed it included a daily restraint when up in the wheelchair (w/c) with a lap buddy in place. The goal stated the resident would have</p>	F 280		

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F 280	<p>Continued From page 22</p> <p>the least restrictive restraint daily thru next evaluation with three (3) approaches: Restraint assessment monthly; remove lap buddy at meal time; and reposition at least every 2 (two) hours.</p> <p>Observation, on 01/30/14 at 9:30 AM, revealed Resident #8 was sitting up in the wheel chair in the television lounge area. The lap buddy was in place to the wheel chair and the resident was leaning over the lap buddy with hand on the head, and dozing.</p> <p>Observation, on 01/30/14 at 10:29 AM, Resident #8 was rolled over to the table, by staff, with six (6) other residents for a Bible reading activity. The lap buddy was not removed.</p> <p>Continued observation, on 01/30/14 at 10:56 AM, and 11:38 AM, revealed Resident #8 remained at the Bible study activity with the lap buddy left in place. At 12:15 PM the Activities Assistant (AA) ask the resident if he/she would like to stay where they were or go to the dining room. The resident responded "it don't matter". The AA rolled the resident into the resident dining area. The lap buddy restraint was never removed.</p> <p>Interview with the Activities Assistant, on 01/30/14 at 1:30 PM, revealed she stated she was not sure if removing the restraints during an activity was still in affect. She stated she probably did not document on the record of Resident #8 of the reason she had not removed the restraint. She stated the purpose of removing the restraint in an activity was because the resident was generally under direct supervision and it would be a good practice to release them.</p> <p>3. Review of the medical record for Resident #16</p>	F 280		

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F 280	<p>Continued From page 23</p> <p>revealed the facility admitted the resident on 08/04/12 with diagnoses including Alzheimer's Dementia with Disturbance in Mood, and Impulse Control Disorder.</p> <p>Review of the Minimum Data Set Annual Assessment, dated 08/08/13, for Resident #16 revealed the facility assessed the residents Basic Interview for Mental Status (BIMS) score at 12, moderately impaired. The facility completed a Quarterly Assessment on 01/24/14 and assessed the residents BIMS sore at 11 moderately impaired.</p> <p>Review of Physician orders for Resident #16 revealed Physical Therapy was ordered on 01/15/14 due to a recent fall. The assessment summary impression from the physical therapy evaluation revealed Resident #16 was positioned well in the wheelchair with no leaning evident; however, nursing reported frequent leaning laterally and anteriorly. Nursing informed of evaluation and nursing reported the patient sometimes falls asleep in the wheelchair and did not have a scheduled nap during the day. Therapy recommendation laying resident down throughout the day to see if it helped with positioning due to the fact leaning and falls might be due to fatigue from sitting in the wheelchair for long periods of time.</p> <p>Review of the Comprehensive Care Plan for Resident #16 revealed a care plan was developed for Restraints on 01/13/14. The care plan consisted of a check list with lap buddy in w/c checked. The only risk factor checked or written was a decline in mobility related to the lap buddy in the wheelchair. The goal was to show no signs and symptoms of decline. Interventions</p>	F 280		

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F 280	<p>Continued From page 24</p> <p>for the restraint care plan included a Restorative Program checked with no description of what would be provided; pressure relieving device checked with no description of what device or when it would be provided; and turning schedule checked with no description of when this would be provided. There was no intervention on the comprehensive care plan to lay the resident down between meals. Review of the Nursing Assistant sheet revealed it did not indicate to lay the resident down between meals.</p> <p>Observation, on 01/30/14 at 9:30 AM, revealed Resident #16 was sitting in the TV lounge area watching TV. A lap buddy was in place to the wheelchair. The resident was alert and conversing with no evidence of leaning in the chair. The resident's speech was somewhat garbled and difficult to understand at times.</p> <p>Observation, on 01/30/14 at 10:19 AM, revealed Resident #16 was sitting up in the wheelchair self propelling the chair and a lap buddy was in place. The AA invited the resident to Bible study.</p> <p>Observation, on 01/30/13 at 10:30 AM, revealed Resident #16 was in the Bible study activity with six (6) other residents. The resident tried to remove the lap buddy, but was unable.</p> <p>Observation, on 01/30/14 at 10:58 AM and 11:35 AM, revealed Resident #16 was sitting up in the wheelchair in the Bible study activity. The lap buddy remained in place. There was no evidence of the resident leaning or falling over in the wheel chair.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 01/30/14 at 1:40 PM, who had provided</p>	F 280		

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F 280	<p>Continued From page 25</p> <p>care for Resident #8 and #16, revealed restraints should be released every two (2) hours and during activities. She stated so the resident did not have to be in the restraint any more than necessary.</p> <p>Interview with CNA #4, on 01/30/14 at 1:50 PM, revealed she had provided care for Resident #8 and #16. She stated restraints should be removed every two (2) hours and at meals. She stated she was not sure if restraints were removed for activities. She stated restraints were removed for comfort of the resident.</p> <p>Interview with the West Unit Manager, on 01/30/14 at 2:08 PM, revealed she stated in regards to Resident #16, they don't always consult Therapy after a fall. She stated they had discussed about laying the resident down for naps. She stated she believed every resident with a lap buddy should be assisted to lay down between meals.</p> <p>4. Observation of Resident #9, on 01/28/14 at 5:10 PM, revealed the resident self propels on the unit and in the halls. The wheelchair seatbelt was on and in use. Observation of Resident #9, on 01/29/14 at 9:35 AM and at 9:50 AM, revealed the seatbelt was on and in use while he/she was in the TV room and near the nurses station.</p> <p>Review of the medical record for Resident #9 revealed the facility admitted the resident on 10/12/11 with Diagnosis including Vascular Dementia, Falls, Late Effect Cardiovascular Disease, Memory Loss, Diabetes Mellitus II and Hypertension. Review of the Device Decision Tree, dated 01/06/12 identified the wheelchair</p>	F 280		

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F 280	<p>Continued From page 26</p> <p>seatbelt alarm was placed as a restraint. A quarterly review of the facility's Device Decision Tree was completed on 01/02/13, 06/21/13 and on 12/11/13. Review of the Review of the Restraint Assessment completed on 01/06/12 revealed the facility placed a seat belt alarm to the wheel chair as a restraint for medical symptoms of an unsteady gait, a history of falls and a history of a Traumatic Subdural Hematoma.</p> <p>Review of the restraint care plan for Resident #9, onset dated as 01/06/12 and goals were dated for 01/2013, 06/2013, 9/2013, 12/2013 and 03/2014. Care plan interventions included toileting schedule, scheduled release of the belt every two (2) hours, as needed and during meals. Additional interventions included therapy as ordered and pressure relieving device, a cushion to the wheelchair. Upon review of the care plan, there were not any interventions to attempt restraint reduction.</p> <p>5. Observation of Resident #15, on 01/29/14 at 4:30 PM, revealed the resident was in the sitting area near the nurses station with the lap tray on the wheelchair. Observation, on 1/30/14 at 9:10 AM revealed he/she was in the wheelchair with the lap tray in place. Observation, on 01/30/14 at 9:40 AM, revealed the lap tray remained on the wheelchair.</p> <p>Review of the medical record for Resident #15 revealed the facility admitted the resident on 06/28/12 and readmitted on 09/23/13 with the diagnosis of Alzheimer's Disease, Dementia without Behavioral Disturbances, Tremors, Iron Deficiency Anemia, Anorexia, Failure to Thrive Adult and Epilepsy. Review of the Restraint</p>	F 280		

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F 280	<p>Continued From page 27</p> <p>Assessment and the Device Decision Tree, dated 08/01/12 identified the lap buddy on the wheelchair was assessed as a restraint. Review of the facility's restraint review for the lap buddy on the wheelchair, dated 07/03/13, 08/23/13, 09/30/13, 10/30/13, 11/27/13 and 12/30/13 revealed the reductive efforts attempted or considered since the last review were not identified; however, care planned interventions were listed as released at meals, during activities and when toileted. Reduction effort interventions were not identified on the care plan.</p> <p>Interview with the East Unit Manager, on 01/30/14 at 2:30 PM, revealed she did initiate and revise care plans, but the Restraint Care Plan was completed by the Assessment Nurse and East Unit Manager stated she never touched that care plan. The East Unit Manager stated she would like to see more goals for reducing the restraint or trail reductions noted on the Restraint Care Plan.</p> <p>Interview with the West Unit Manager, on 01/30/14 at 2:08 PM, revealed she was not responsible for restraint assessments or documentation. She stated restraints should be removed every two (2) hours, during meals, activities and situations where there was direct supervision. She stated there needed to be some revisions for restraint care plans.</p> <p>Interview with the Assessment Nurse, on 01/30/14 at 3:50 PM, revealed she had been in that role for six (6) months and she was responsible to ensure there was a Restraint Care Plan and updated as needed. She was not aware the care plan should have been more individualized, such as attempting trial reductions, or the monitoring of risk factors for the resident.</p>	F 280		

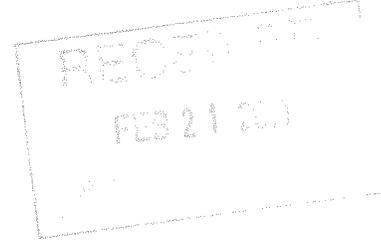
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F 280	<p>Continued From page 28</p> <p>The Assessment Nurse stated she could see how the Restraint Care Plan could be more individualized.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 01/30/14 at 3:30 PM, revealed she was not responsible to update the restraint care plan because she did not attend the meetings. Further interview with the MDS Coordinator, revealed she could see how the Restraint Care Plan could be individualized more especially with no goal outlined for reduction of the restraint or why the restraint was put into affect.</p> <p>Interview with the Director of Nursing (DON), on 01/30/14 on 3:00 PM, revealed the Unit Managers, MDS Coordinators, Nurses and Desk Nurses could update the Restraint Care Plan. In addition, the care plan could be more personalized, such as reductions and utilizing the least restrictive and giving appropriate time tables for completing the tasks.</p>	F 280		
F 465 SS=E	<p>483.70(h) - SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure handrails were maintained in a safe manner. Observation revealed three (3) of eight</p>	F 465	<p>F 465</p> <p>Handrails on the 300, 400, and 600 hallways were observed to have missing chunks of wood and rough to touch. These hand rails were sanded and chunks filled in immediately. All other hand rails in the building have been evaluated by Maintenance Assistant and checked for roughness and missing chunks of wood. All handrails will be audited monthly by Maintenance Assistant for six months then quarterly after that to ensure smooth surfaces on handrails with now pieces of wood missing and that they have been sanded and holes filled in. Maintenance Supervisor will ensure that these audits</p>	<p>Completion Date: 03/11/2014</p>



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F 465	<p>Continued From page 29</p> <p>(8) hallways had handrails that were splintered with missing chunks of wood on Hall 300, 400, and 600. Observation revealed residents used the handrails to assist them down the hallways.</p> <p>The findings include.</p> <p>The facility did not provide a policy specific to repair of the handrails.</p> <p>Observation during the environmental tour, on 01/29/14 at 2:10 PM- 2:30 PM, revealed on the 300 Hall a portion of the handrail had a large chunk of wood missing. The area was rough to touch. Observation of the 400 Hall revealed rough, chipped wood between rooms 403 and 405 and another portion at room 411. Observation revealed a resident was using the handrail to pull themselves down the hallway in their wheelchair. Observation of the 600 Hall revealed a portion of the handrail between rooms 603-605 that was splintered with chipped wood and rough to touch.</p> <p>Interview with the Director of Maintenance, on 01/29/14 at 2:45 PM, revealed he did not have a routine schedule to check and repair the handrails. He stated he relied on housekeepers and nursing to report any problems with the handrails. They were supposed to document the problem on the work order log. The Maintenance department would check those logs several times a day and complete the work.</p> <p>Review of the work order logs for both the East and West units revealed no documentation regarding any handrail problems.</p>	F 465	<p>Are done timely and will keep these findings on a preventative maintenance log. These findings will be reported to the QA Committee on a quarterly basis by Maintenance Supervisor.</p>	<p>Completion Date: 03/11/2014</p>

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1986, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (Unprotected)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II, 150 KW generator, Fuel source is diesel.</p> <p>A standard Life Safety Code (LSC) Short Form Survey was conducted on 01/28/14. North Hardin Health and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000			

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

TITLE

(X6) DATE

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.