

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

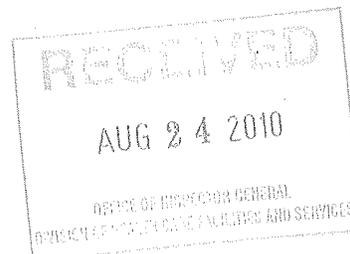
PRINTED: 08/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2010
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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 250	Continued From page 3	F 250		
F 253 SS=E	<p>for mood for Resident #2, as she had a hard time adjusting when the resident had to be readmitted.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</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 and interview the facility failed to ensure housekeeping and, or maintenance services maintained a sanitary, orderly and comfortable interior. There were six (6) resident sinks with overflow outlets damaged, walls with gouges, faucets with leaks and mineral deposits, base boards torn and taped to the wall, a hot curling iron left unattended, a shower chair and toilet seat with a dried brown substance, detergent and nail polish remover at a resident's sink. In addition, the men's bathroom door had been broken for one month and flies were in the dining room, nurse's station, common areas, two hundred (200) hall, and six hundred (600) hall.</p> <p>The findings include:</p> <p>Observation of resident rooms 406, 503, 601, 604, 607, and 611 on 07/28/10 at 8:20am, and at 4:10pm revealed compromised surface integrity on the residents' sink overflow outlet, with exposed sharp, fragmented and rough edges to the touch. The above named rooms had sinks with red stained streaks from the overflow outlets, and loose particles fell out of the outlet into the sink.</p>	F 253	<p>F 253/N 134</p> <ol style="list-style-type: none"> The resident sinks in room 406, 503, 601, 604, 607 and 611 were all replaced by 8/17/10. The wall gouges in room 410; faucets with leaks and mineral deposits in rooms 103 and 303; and a torn baseboard in room 201 will be repaired by 8/25/10. There were no residents affected by the unattended curling iron in room 206 and an in-service was completed by 8/21/10 to prevent the issue from reoccurring. The brown substance on the toilet and shower chair was addressed and corrected on 7/28/10. The dishwasher detergent and nail polish remover was removed from room 612 on 7/29/10. A fly light was installed in the dining room, at each nurse's station and in all common areas to help eliminate the insect problem on 8/12/10. The B-side men's bathroom door will be replaced by 9/10/10. An audit of all other rooms and common areas was conducted on 8/2/10 to identify any other repairs, pest control issues, safety hazards or sanitary concerns. All areas will be corrected by 9/10/10. The Administrator/designee conducted an in-service addressing environmental conditions, pest control problems, sanitary concerns and safety hazards that will be completed 8/21/10. A weekly maintenance log was implemented and a binder is located at each nurse's station to communicate any environmental concerns. The facility has added more specific identification of environmental concerns or hazards through the 	



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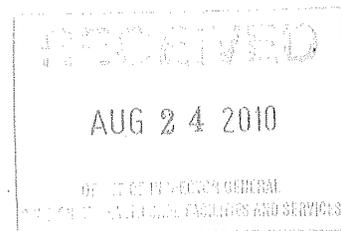
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F 253	<p>Continued From page 4</p> <p>Observation of resident room #612 on 07/28/10 at 8:26am revealed a twenty-four ounce container of blue liquid, store labeled as Dawn dishwasher detergent that was half full, and a fourteen ounce container of blue liquid, store labeled as Dawn dishwasher detergent with one (1) inch of blue liquid on the shelf over the sink in the resident's room. In addition, there was a six (6) ounce container greater than half full of store labeled finger nail polish remover on the vanity in the resident's room.</p> <p>Observation of resident room #201 on 07/28/10 at 9:13am revealed a sixteen (16) inch strip of loose base board that had been secured with blue tape, with areas still remaining unsecured.</p> <p>Observation of resident room #206 on 07/28/10 at 9:05am revealed a curling iron plugged into the electric socket, turned on high, and hot to the touch. The hot curling iron was left unattended.</p> <p>Observation of resident room #410 on 07/28/10 at 8:56am revealed a twelve (12) inch by two (2) inch lateral gouged wall surface between the air conditioner and the corner of the wall.</p> <p>Observation of resident room #103 and room #303 on 07/28/10 at 9:22am revealed the cold water faucet had a continuous leak with a white mineral build up on the handle and faucet.</p> <p>Observation of flies on 07/28/10 at 10:18am in the B Nurses Station and in the 400 hallway at 5:08pm revealed a fly landed on a resident. Observation again at 4:40pm in resident room #207 revealed a fly landed on that resident.</p> <p>Observation of the men's resident bathroom door</p>	F 253	<p>orientation checklist with new hires. The monthly facility newsletter will be used to educate families as to what is considered to be an environmental or hazardous item. By doing this, families will be aware as to what cannot be brought into the building by September 5, 2010.</p> <p>4. The QA nurse or designee will conduct room audits biweekly for the first quarter and monthly thereafter to ensure compliance with environmental, sanitary or hazardous concerns. Maintenance/ designee will conduct weekly room inspections for the first quarter and monthly thereafter to ensure compliance. The findings will be presented to the Quality Assurance committee monthly.</p> <p style="text-align: right;">Completion date: 9/10/10</p>	
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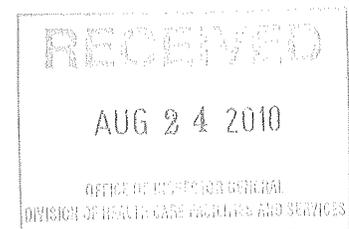
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F 253	<p>Continued From page 5</p> <p>near Nurses Station B on 07/27/10 at 10:22am and on 07/28/10 at 8:40am revealed a sign on the door that identified the bathroom as out of order. The wooden door had wood split at the floor hinge and the door facing separated.</p> <p>Observation of resident room #301's bathroom on 07/27/10 at 1:20pm and on 07/28/10 at 2:00pm revealed dried brown substance on the toilet seat.</p> <p>Observation of the high back shower chair in the shower room near Nurse's Station B on 07/28/10 at 8:44am revealed the blue seat cushion had brown substance dried to the seat.</p> <p>Interview with the Director of Maintenance (DOM) on 07/28/10 at 5:10pm revealed he was unaware that the sinks had any problems. He reported he had changed out some of the sinks, but only changed sinks when he received a work order from staff or housekeeping that there was a problem with them. He reported the red stain is a rust stain on the sink and the loose particles are loose rust that fell from the rusty overflow outlet. The DOM reported he did not have a tracking tool or method in place for routine room evaluations to ensure the residents' rooms remained sanitary, orderly, and in good condition. He reported the residents are not to keep any detergents or chemicals in their rooms. He reported the heated appliances and curling irons are to be unplugged after use. The DOM reported he has fixed the base board in room #206 before and that the resident knocks it loose with the wheelchair. The DOM reported he was unaware of the gouged wall surface in room #410. He also reported he was unaware of the leaky faucets and stated the white particles on the handles and the faucet was mineral build up since it had been leaking for</p>	F 253		
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F 253	Continued From page 6 awhile. He reported there are two (2) flying insect lights in the facility and they have a pest control contract, but reported this does not help a lot with flies, and he recommended they needed a fly swatter. In addition, the DOM reported housekeeping is responsible for cleaning the bathrooms and the equipment. Interview with the Adminlstrator on 07/28/10 at 12:08pm revealed the door had been broken approximately one month ago when a resident ran into the door with his motorized wheelchair. She reported this has been a work in progress to replace the door. She reported she has gone through the local hardware store and hopes to have the door and the door facing replaced soon. The administrator was unable to provide a definitve time line of when the door would be replaced and available for resident use.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279 F 279/ N 185	1. The facility obtained a copy of the hospice care plans for resident #17 (closed record) to remain in her discharged chart. Resident # 14 was identified as not having a comprehensive care plan. An end of life comprehensive care plan was implemented and placed on the chart by 8/17/10. 2. An audit was conducted of all hospice residents and an end of life comprehensive care plan was implemented by 8/20/10. 3. The systemic change was the development of an end of life comprehensive care plan that integrates the care received by the facility in conjunction with hospice services. The facility also developed a hospice admission checklist to	

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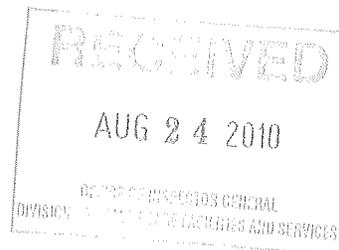
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F 279	<p>Continued From page 7</p> <p>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to develop a comprehensive plan of care for two (2) residents (#14 and 17) of the eighteen (18) sampled residents to address end of life care and needs.</p> <p>The findings include:</p> <p>1. Review of the Hospice contract dated November 2009 revealed Article I, Definitions (B) Eligible Residents: 5. Receive Hospice services in accordance with an individualized Hospice Plan of Care developed by Hospice consultation with facility representatives and approved by the physician identified on the Medicare Hospice Benefit Election form as being responsible for the individual's health care and the Hospice Medical Director; (J) Hospice Patient Plan of Care or "Plan of Care":...all hospice care provided must be in accordance with the Hospice Plan of Care. The Hospice Plan of Care shall specify which services and supplies are related to the patient's terminal illness and therefore, shall be furnished or paid for by Hospice. Article II Services To Be Furnished By Hospice: ...the plan of care is established and maintained in consultation with the Facility representatives; (A) Hospice Plan of Care:a copy of which shall be furnished by Hospice to Facility at the time an Eligible Resident is admitted as a Hospice Patient; (5) Be reviewed and updated as needed based on the Hospice Patient's condition, but no less frequently than</p>	F 279	<p>ensure that proper documentation from both facility and hospice is available at time of admission. Hospice will be printing care plans via facility copier rather than home office to ensure immediate availability for the medical record by 8/ 25/10.</p> <p>4. The QA nurse / designee will audit residents newly admitted to Hospice within twenty-four hours to ensure compliance with integration of the comprehensive care plan. The findings will be reported to the Quality Assurance committee monthly.</p> <p style="text-align: right;">Completion date: 8/25/10</p>	
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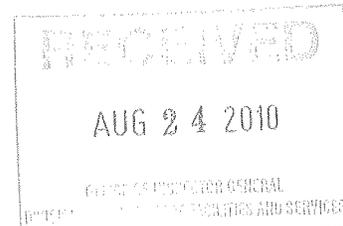
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F 279	<p>Continued From page 8</p> <p>every fourteen (14) days. Exhibit D Clinical Responsibility Checklist: Development of clinical care plan- Hospice and Facility; Care plan revision- Hospice and Facility;</p> <p>Record review for Resident #17 revealed an admission date of 01/18/10 and a readmission date of 07/06/10 with diagnoses of Malignant Neoplasm of Soft Tissue, Secondary Malignant Neoplasm of Lungs and Large Bowel, Anorexia, Dysphagia, Esophagitis, Depression, Muscle Weakness, Difficulty Walking, Diabetes Type 2, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The resident expired on 07/07/10. The Admission MDS dated 07/06/10 indicated the resident was more lethargic most likely due to the addition of Morphine, was refusing to eat, required assistance with walking, had two stage II pressure areas and was not receiving Hospice care. However, the Hospice note dated 07/06/10 indicated the resident was admitted to Hospice on 07/06/10 and the admission nursing note dated 07/06/10 indicated the resident was readmitted to Hospice and would be comfort measures. The Hospice notes indicated the resident was to be seen by the Hospice nurse, Social Services, Chaplain and a nursing assistant. Record review did not reveal a Hospice plan of care and review of the facility's plan of care developed 07/06/10 did not reveal an integration or mention Hospice services for Resident #17. The Hospice plan of care was delivered to the facility on 07/29/10, twenty-two (22) days after the resident expired.</p> <p>Interview with the MDS Coordinator on 07/29/10 at 2:50pm revealed the facility plan of care for Resident #17 did not address Hospice Services and therefore was not a comprehensive plan of</p>	F 279		
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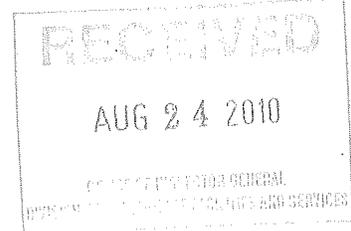
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F 279	<p>Continued From page 9 care.</p> <p>Interview with Social Services on 07/29/10 at 3:05pm revealed Resident #17 should have been care planned for Hospice services; however, it was too difficult to keep up with the resident due to all the hospital transfers. The care plan should have been developed to reflect Hospice when it was started.</p> <p>Interview with the Hospice RN on 07/29/10 at 11:50am revealed Hospice is involved in the care plan process by attending care plan meetings, monthly meetings and one on one meetings. The Hospice RN confirmed Hospice services were not identified on the comprehensive plan of care and the Hospice plan of care was not in the record; however, it would have to be sent to the survey team. The Hospice RN further stated she felt she provided all the information needed to the facility for staff to provide care and staff could call the posted number with questions.</p> <p>2. Record review for Resident #14 revealed the resident was admitted on 10/12/06 with diagnoses including Dementia, Alzheimer's, and Depression. Review of the Quarterly Minimum Data Set (MDS) assessment completed on 03/26/10 revealed Resident #14 had a decline related to ambulation, mobility and eating, as well as, a weight loss of fifteen (15) pounds from 08/19/09-03/26/10. The resident had a living will and was a Do Not Resuscitate (DNR). The family requested Hospice care and refused Feeding Tube placement per resident request. An order was received on 03/17/10 for Hospice Care.</p> <p>A review of the Comprehensive Care Plan for Resident #14 revealed an intervention of Hospice</p>	F 279		
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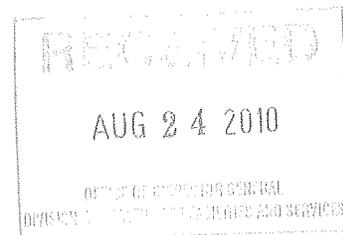
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F 279	Continued From page 10 Care. There was no indication of what care the facility was to provide and what services Hospice would provide. The record revealed that Hospice did have a care plan on the record for the resident, but it was not integrated into the Residents Comprehensive Plan of Care. Specific interventions listed on the Hospice Care Plan were not carried over to the Comprehensive Care Plan for Resident #14. Interview with the Hospice RN on 07/29/10 at 11:50am revealed Hospice is involved in the care plan process by attending care plan meetings, monthly meetings and one on one meetings. The Hospice RN further stated she felt she provided all the information needed to the facility for staff to provide care and staff could call the posted number with questions. Interview with the MDS Coordinator on 07/29/10 at 2:50pm revealed the facility plan of care for Resident #14 did not address Hospice Services and therefore was not a Comprehensive Plan of Care.	F 279		
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	F 280 F 280/ N 192	1. The facility reviewed residents #1, #2, #4, #12, #13 and #14 and comprehensive end of life care plans were implemented by 8/20/10 to include specific Hospice interventions. Facility also developed a checklist to identify the additional services provided by the Hospice staff for the care provided. The checklist was implemented on 8/20/10.	



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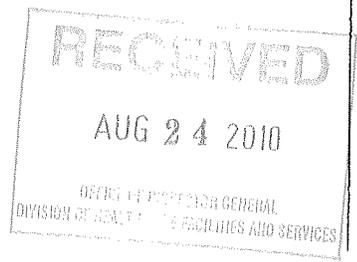
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F 280	<p>Continued From page 11</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to revise the Comprehensive Plan of Care for six (6) of eighteen (18) residents who were receiving Hospice care. Residents #1, #2, #4, #12, #13, and #14's Comprehensive Plan of Care did not include specific interventions of services that Hospice Care was to provide.</p> <p>1. Record review for Resident #2 revealed an admission date of 10/09/09 with diagnoses including Diabetes, Senile Dementia, Chronic Obstructive Pulmonary Disease (COPD), and Anxiety. An order was received on 06/10/10 for Hospice care related to end stage COPD.</p> <p>A review of the Comprehensive Care Plan for Resident #2 revealed an intervention of Hospice Care was on the care plan. There was no indication of what care the facility was to provide and what services Hospice would provide. The record revealed that Hospice did have a care plan on the record for Resident #2, but it was not integrated into the residents Comprehensive Plan of Care. Specific interventions listed on the Hospice Care Plan were not carried over to the Comprehensive Care Plan for Resident #2.</p>	F 280	<p>2. An audit on all residents receiving Hospice care was completed by 8/20/10 to ensure the integration of services. An end of life care plan was implemented to include specific Hospice interventions.</p> <p>3. A checklist was developed to identify the additional services provided by the Hospice staff for the care provided. The facility also implemented an end of life care plan to include specific Hospice interventions. Additionally, the facility has implemented an interdisciplinary care conference upon admission to ensure proper communication between entities.</p> <p>4. The QA nurse/ designee will conduct biweekly audits for six months and monthly thereafter to ensure compliance with the Hospice checklist and comprehensive care plans. The findings will be presented to the Quality Assurance committee monthly.</p> <p style="text-align: right;">Completion date: 8/20/10</p>	
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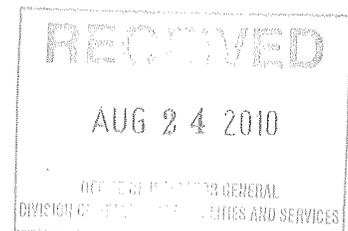
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2010
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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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F 280	<p>Continued From page 12</p> <p>2. Record review for Resident #14 revealed the resident was admitted on 10/12/06 with diagnosis including Dementia, Alzheimer, and Depression. Review of the Quarterly Minimum Data Set (MDS) assessment completed on 03/26/10 revealed that Resident #14 had a decline related to ambulation, mobility and eating. Resident #14 had a weight loss of fifteen (15) pounds from 08/19/09-03/26/10. The resident had a living will, and was a Do Not Resuscitate (DNR). The family of Resident #14 requested Hospice care and refused Feeding Tube placement per resident request. An order was received on 03/17/10 for Hospice Care.</p> <p>Review the Hospice plan of care, located in a separate section of the record, dated 03/17/10 which indicated the resident was to be seen by the Registered Nurse bi-weekly, the Social Worker bi-weekly, the Chaplain once every 3-4 weeks and a nursing assistant two time a week.</p> <p>A review of the comprehensive care plan for Resident #14 revealed an intervention of Hospice Care was on the care plan. There was no indication of what care the facility was to provide and what services Hospice was to provide. Record revealed that Hospice did have a care plan on the record for Resident #14, but it was not integrated into the residents Comprehensive Plan of Care. Specific interventions listed on the Hospice Care Plan were not carried over to the Comprehensive Care Plan for Resident #14.</p> <p>3. Review of the medical record for Resident #4 revealed an admission date of 12/01/09 with diagnoses including Dysphagia, Fracture Hip, Dementia, Atrial Fibrillation, and</p>	F 280		
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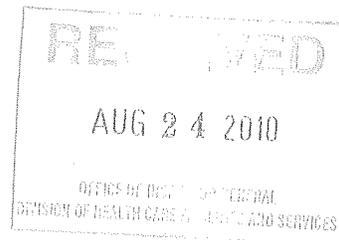
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F 280	<p>Continued From page 13</p> <p>Hypoalbuminemia. An order was received on 05/27/10 for Hospice care for Resident #4.</p> <p>A review of the Comprehensive Care Plan for Resident #4 revealed Hospice care, and comfort measures only. There were no specific interventions on the care plan of what services Hospice would provide. The Hospice Care Plan had intervention listed, but this care plan was located in a different section of the chart. Interventions from the Hospice Care Plan were not carried over to the care plan for Resident #4.</p> <p>Interview with a Hospice RN on 07/29/10 at 11:50am revealed Hospice is involved in the care plan process by attending care plan meetings, monthly meetings and one on one meetings. The Hospice RN further stated she felt she provided all the information needed to the facility for staff to provide care and staff could call the posted number with questions.</p> <p>Interview with the MDS Coordinator on 07/29/10 at 2:50pm revealed specific interventions to determine care for ill residents should be on the care plan. Hospice and the facility is one care plan; however, mental, emotional and spiritual needs are part of the Hospice Care Plan. The Resident Assessment Instrument (RAI) process requires a Comprehensive Care Plan but the facility care plan did not address spiritual needs; therefore, it is not a Comprehensive Care Plan. Things could get missed if not a Comprehensive Care Plan. All the information when doing the care conference with the facility and Hospice should provide a Comprehensive Care Plan.</p> <p>4. Record review for Resident #1 revealed an admission date of 03/17/09 and diagnoses of</p>	F 280		
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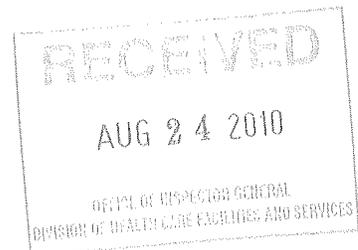
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F 280	<p>Continued From page 14</p> <p>Adult Failure to Thrive, Chronic Pain and Dementia. The Annual MDS dated 02/19/10 indicated the resident was receiving Hospice services that were initiated on 04/07/09. Review of the facility's Comprehensive Plan of Care dated 02/16/10 did not reveal any interventions for end of life care needs or the integration of Hospice into the Comprehensive Care Plan.</p> <p>Review the Hospice Plan of Care, located in a separate section of the record, dated 04/07/09 which indicated the resident was to be seen by the Registered Nurse bi-weekly, the Social Worker bi-weekly, the Chaplin once every 3-4 weeks and a nursing assistant two times a week. In addition, the Hospice staff would educate the patient and care giver regarding disease process and care requirements. Provide ongoing assessment of pain and non-pain related symptoms, implement fall precautions, and develop and implement a comprehensive social care plan that addresses the social, practical and legal needs of the patient and caregiver. Review of the Comprehensive Plan of Care dated 11/03/09 revealed the resident was to be monitored for impending death, educated on the actively dying phase, encourage family to contact and finalize funeral plans, coordinate care with patient, caregiver and attending physician, arrange for equipment as necessary, ongoing assessment of pain and non-pain symptoms, address nutrition choices, fall precautions, adequate supply of medications, facilitate contacts with spiritual, religious or individuals as desired, implement a risk management plan.</p> <p>Interview with a Hospice RN on 07/29/10 at 11:50am revealed Hospice integrates into the facility care plan by attending the careplan</p>	F 280		
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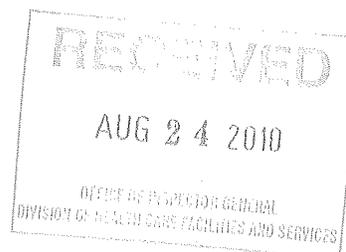
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F 280	<p>Continued From page 15</p> <p>meetings for Hospice residents, monthly meetings and one on one meetings. She feels she provides all the information needed to the facility for staff to provide care. If the nurse has questions regarding Hospice care for a specific resident they can call the posted number on the chart.</p> <p>Interview with the RN, MDS Coordinator on 07/29/10 at 2:50pm revealed when a resident has Hospice it is an added service. If the family opts for Hospice then it is up to the MDS to do a significant change and if no significant change is completed MDS will update the care plan. Specific interventions to determine care for ill residents should be on the care plan. Hospice and the facility is one care plan. However, mental, emotional and spiritual needs are part of Hospice Care Plan. RAI process requires a Comprehensive Care Plan and the facility care plan did not address spiritual needs. Therefore it is not a Comprehensive Care Plan. The MDS stated things could get missed if not a Comprehensive Care Plan. All the information when doing the care conference with the facility and Hospice should provide a Comprehensive Care Plan.</p> <p>5. Record review on 07/29/10 at 8:30am of Resident #12 revealed an admission on 11/09/05 with diagnoses of Subdural Hematoma, Right Sided Weakness, End Stage Dementia, Dysphagia, G-tube, Diabetes, High Blood Pressure, and GERD. An order was received on 03/23/03 for hospice care related to End Stage Dementia.</p> <p>A review of the Comprehensive Care Plan revealed Resident #12 had an intervention for</p>	F 280		
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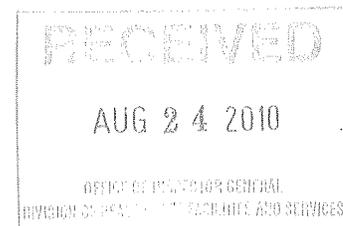
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F 280	<p>Continued From page 16</p> <p>Hospice care. A review of the Hospice Care Plan located in another part of the medical record revealed that the Hospice plan of care dated 03/29/10 had not been integrated into the Comprehensive Plan of Care for ADL, spiritual, and comfort needs of Resident #12.</p> <p>6. Review of the clinical record for Resident #13 revealed the resident was admitted to the facility with diagnoses of Dementia with Behavior Disorder, Diabetes, and Mute. The facility completed a significant change Minimum Data Set (MDS) assessment on 05/26/10 which revealed the resident had declined in function and cognition and required extensive assistance from staff for ambulation, transfer, eating, and bathing. On 06/03/10, the physician ordered Hospice care for the resident.</p> <p>Review of the Comprehensive Care Plan for Resident #13 revealed the resident required extensive care for turning, dressing and transfers, and total care for bathing and hygiene and was incontinent; however, there were no interventions in place for the Hospice nurse aide to perform any care during visits. The resident had a terminal diagnosis and received psychotropic medications; however, there were no interventions on the care plan for the Hospice Social Worker or Chaplain to provide any care during their visits.</p> <p>Review of the Hospice Care Plan dated 06/03/10 revealed the plan was in a different section of the clinical record.</p> <p>Interview with the MDS Coordinator on 07/29/10 at 2:50pm, revealed the word, hospice, had been added to the bottom of each of Resident #13's Comprehensive Care Plan problems. She stated</p>	F 280		
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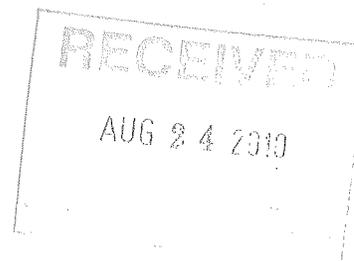
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F 280	Continued From page 17 that Hospice wrote their own care plan. She indicated that the Comprehensive Care Plan did not include any individualized Hospice interventions for the resident.	F 280		
F 315 SS=D	Interview with the Director of Nursing on 07/29/10 at 3:35pm, revealed the Comprehensive Care Plan should be complete and address all needs and include hospice. She stated the care plan should be individualized to each resident and draw a picture of the resident's needs. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observations it was determined the facility failed to provide care and services to prevent infection for one (1) resident (#1) of the eighteen (18) sampled residents. Resident #1 had a urinary catheter drainage bag and tubing with direct contact to the floor on two occasions. The findings include: Review of the facility's policy on Catheter	F 315	F 315/ N 214 1. Resident #1's catheter bag and tubing was resecured on 7/28/10 to avoid direct contact with the floor. 2. The facility conducted an audit of all residents with indwelling catheters and found no further deficient practice on 7/29/10. 3. The Staff Development initiated an in-service for all nursing staff on the proper care and maintenance of Foley catheters to prevent the spread of infection. This was completed on 8/21/10. A competency evaluation will be completed during orientation to ensure proper care of Foley catheters as well as biannual in servicing for the nursing department. 4. The QA nurse/designee will be auditing weekly for four weeks and monthly for three months then quarterly thereafter to ensure compliance with Foley catheter care. The findings will be presented to the Quality Assurance committee monthly. Completion date: 8/21/10	



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F 315	<p>Continued From page 18</p> <p>(Indwelling); insertion and removal of (female and male) revealed Procedure step 14: at no time should the tubing be placed above the level of the bladder to allow back flow of urine into the bladder; step 15: secure urinary drainage bag below the level of the bladder and keep off the floor at all times, coil extra tubing and secure. Catheter Care procedure revealed step 10: to secure catheter properly, coil and secure tubing to the bed.</p> <p>Record review for Resident #1 revealed an admission date of 03/17/09 and diagnoses of Adult Failure to Thrive, Joint Stiffness, Chronic Pain, Dementia and Anxiety. Review of the annual Minimum Data Set (MDS) dated 02/19/10 revealed the resident utilized a urinary catheter drainage system for Urinary Retention. Review of the Plan of Care for indwelling catheter indicated the resident was to be monitored for signs and symptoms of infection.</p> <p>Observations on 07/28/10 at 12:10pm and 12:20pm revealed Resident #1 sitting in the dining room for lunch and the urinary catheter tubing and drainage bag were in direct contact with the floor while staff sat to assist with feeding at the table. On 07/28/10 at 2:30pm the resident was lying in bed with the urinary drainage bag and tubing resting on the floor.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 07/29/10 at 10:25am revealed the catheter bag should be hung under the chair in the dignity bag. It must have fallen off the chair, it has done that before. In addition, the SRNA could not state the reason why the catheter bag and tubing should not be on the floor.</p>	F 315		
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F 315	Continued From page 19 Interview with the Kentucky Medication Assistant (KMA) on 07/29/10 at 10:10am revealed the catheter should be cleaned every shift and placed in a dignity bag, as well as being emptied every shift. The drainage bag is placed on the railing of the bed and the back of the chair underneath. The KMA stated there is a risk of infection when the bag is on the floor and should not be touching the floor due to infection control. Interview with Licensed Practical Nurse (LPN) #8 on 07/29/10 at 9:10am revealed the drainage bag should be placed in a dignity bag and hooked onto the bed, but sometimes it slides under the bed. However, it should not touch the floor. The LPN stated it is not sanitary when touching the floor and a risk for contamination of the resident and whoever is handling the indwelling catheter bag. Interview with the Staff Development /Infection Control Coordinator on 07/29/10 at 10:35am revealed there was no documented evidence of staff training or education on proper storage of indwelling catheter drainage bags and the rationale.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

REC'D
AUG 24 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES