

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

PRINTED: 08/16/2012
FORM APPROVED
CMS NO. 0938-0391

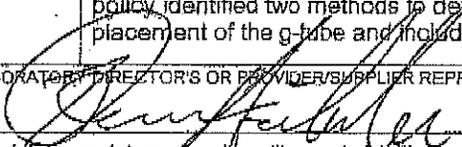
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED AUG 27 2012	(X3) DATE SURVEY COMPLETED 08/02/2012
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSBURG, KY 40397 Division of Health Care Southern Enforcement Branch
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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 000	INITIAL COMMENTS A standard health survey was conducted on 07/31/12 to 08/02/12. Deficient practice was identified with the highest scope and severity at "D" level.	F 000		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	F322 1. Resident C was assessed by the Director of Nursing on July 31, 2012 to verify G-tube placement. Resident C was monitored by nursing staff for 72 hours post medication administration on 7/31/2012 for change in condition; no change in condition was noted. LPN #1 was re-educated by the Director of Nursing on July 31, 2012	

	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate treatment and services were provided for one unsampled resident observed to receive g-tube medications (Resident C). Facility staff failed to verify placement of Resident C's gastrostomy tube prior to administering medication to the resident. The findings include: A review of the Care of Gastrostomy Tube (g-tube) policy (no date) revealed routine nursing care for g-tube included placement of the g-tube would be checked prior to any feeding or administration of medication into the g-tube. The policy identified two methods to determine placement of the g-tube and included for staff to		on procedure to validate proper G-tube placement prior to medication administration. 2. Residents who receive nutrition or medication administration via G-tube were assessed by the licensed nurse on July 31, 2012 to verify G-tube placement and for change in condition. No change in condition was noted. 3. The Director of Nursing and/or Assistant Director of Nursing will provide re-education to licensed nurses on "Care of Gastrostomy Tube" policy by August 27, 2012. Re-education will include procedure to verify G-tube placement prior to medication administration.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/27/12
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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 her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 322	<p>Continued From page 1</p> <p>aspirate stomach contents into a syringe, or to inject 10 cubic centimeters (cc) of air into the g-tube and listen by the placement of a stethoscope over the resident's stomach for a "whooshing" sound.</p> <p>Review of the medical record revealed the facility readmitted Resident C on 05/01/12, with diagnoses to include Hemiplegia due to cerebrovascular disease, Pneumonitis due to inhalation of food or vomitus, and Dysphagia (difficulty swallowing).</p> <p>Review of the annual comprehensive assessment, with a reference date of 05/24/12, revealed Resident C was assessed to require g-tube feedings to meet his/her nutritional needs and to require the total assistance of staff with eating.</p> <p>Observation conducted during medication administration on 07/31/12, at 6:05 PM, revealed facility staff administered Amoxicillin (antibiotic) 875-125 milligram tablet and 0.6 milliliters of Mylicon (anti-flatulent) to Resident C through the resident's g-tube. However, staff failed to verify placement of the g-tube prior to administering the medications to the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/31/12, at 6:25 PM, revealed she did not verify correct placement of the g-tube prior to administering medications to Resident C. The LPN stated she was required to check g-tube placement by injecting 10 milliliters of air into the tube and listening with a stethoscope. LPN #1 stated she "forgot" to appropriately check the g-tube placement prior to giving the medications</p>	F 322	<p>4. The Director of Nursing , Assistant Director of Nursing or Unit Managers will complete G-tube skills competency audit of licensed nurses caring for G-Tube residents two times weekly for four weeks, then four times monthly for two months with results to be reviewed monthly in Performance Improvement Committee meeting for any further recommendations.</p> <p>5. Completion date: August 28, 2012</p>		

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F 322	Continued From page 2 to Resident C.	F 322		
F 364 SS=D	Interview with the Director of Nurses (DON) on 08/02/12, at 3:00 PM, revealed staff should verify g-tube placement prior to administering medications to the residents by injecting air into the tube and listening with a stethoscope. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	F364 1. Residents residing in the center benefit from seasoned meals. 2. The Dietary Manger interviewed cognitively intact residents on August 20, 2012 to determine resident satisfaction with meals. Based on the suggestions for additional meal seasoning made by center residents during interviews, the Dietary manager in consultation with the Dietician and Regional Dietician modified or updated recipes as necessary on August 24, 2012.	
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prepare food served to residents with an adequate amount of seasoning. Seven alert residents attending the Group Interview at 3:30 PM on 07/31/12, revealed meals prepared in the Dietary Department were bland and needed more seasoning. The findings include: Interview with the Dietary Manager at 6:30 PM on 08/02/12, revealed the facility did not have a policy/procedure for seasoning the food. Observation of the menu for 08/01/12 and the noon meal at 12:05 PM on 08/01/12, revealed residents were served Salisbury steak, mashed potatoes, and greens. Observation of the steam table at 12:05 PM on 08/01/12, revealed the			

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F 364	Continued From page 3 steam table also contained fortified potatoes for residents needing additional calories. A review of the recipe for the mashed potatoes (instant) revealed 8 ounces of butter, 16 ounces of whole milk, 4 teaspoons of salt, and 1/2 teaspoon pepper were to be added to the instant potatoes. The Group Interview was conducted at 3:30 PM on 07/31/12, with seven alert residents attending. The residents stated the facility (kitchen) did not use enough seasoning in the food. A palatability test was conducted accompanied by the Dietary Manager at 1:10 PM on 08/01/12 of the noon meal. The palatability test revealed the mashed potatoes (instant) and the fortified mashed potatoes tasted bland and did not have enough seasoning.	F 364	3. The Dietary Manager re-educated center cooks on August 22, 2012 on the location of recipes in the kitchen and to follow recipes during meal preparation. 4. A food committee meeting will be held weekly with the Dietary Manger and Administrator for four weeks, then monthly for two months to determine resident satisfaction with seasoning the meals. Results to be reviewed monthly in Performance Improvement Committee meeting for any further recommendations.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	5. Completion date: August 28, 2012	

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F 441	<p>Continued From page 4</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>F441</p> <p>1. Residents A and B were assessed by the Director of Nursing on 7/31/2012 and then monitored for 72 hours by Licensed Nurses for signs or symptoms for infection. Neither resident had any change in condition.</p> <p>Resident #3 was identified at the survey exit on August 2, 2012. Resident #3 was assessed by Director of Nursing on August 2, 2012 with no change in condition or signs/symptoms of infection noted.</p> <p>LPN #1 was immediately re-educated on the guidelines for glucometer cleaning "Care of Glucometers" by Director of Nursing on July 31, 2012.</p>	
	<p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of nineteen sampled and two unsampled residents selected for observation and/or review (Resident #3 and unsampled Residents A and B). Observation of a blood glucose monitoring test on</p>		<p>2. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers reviewed the 24Hour Report of Resident Change in Condition reports from 7/31/2012 thru 8/5/2012 to determine possible resident changes in condition including infection.</p>	

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F 441	Continued From page 5 07/31/12, revealed facility staff failed to clean/sanitize the glucometer machine prior to and/or after obtaining a blood specimen to check Residents A and B's blood sugar level. In addition, facility staff failed to perform appropriate handwashing techniques when conducting a skin assessment for Resident #3 on 08/02/12, at 5:10 PM. The findings include: Review of the facility's Care of Glucometer policy (updated June 2011) revealed the facility staff was responsible to clean and disinfect the glucometer machine between resident uses. The policy noted the staff would use a 1:10 bleach wipe to clean/sanitize the glucometer before and after each resident use.	F 441	3. The Director of Nursing and/or Assistant Director of Nursing will provide re-education to licensed nurses on center guidelines for glucometer cleaning "Care of Glucometers" by August 27, 2012. LPN #1 was re-educated on August 2, 2012 on hand hygiene and glove use by Director of Nursing. The Director of Nursing and/or Assistant Director of Nursing will provide re-education to Licensed Nurses and Certified Nursing Assistants on hand hygiene and glove use guidelines according to center Infection Control Manual by August 27, 2012.		
	Review of the facility policy titled "Section 10: Precaution guidelines," dated January 2008, under "Standard Precautions" the hand washing section revealed hands must be washed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. According to the policy, staff was to wash hands immediately after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environmental surfaces. The facility's policy further revealed it may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites. Additionally, the facility's policy revealed under the section labeled "Gloves" that gloves must be changed between tasks and procedures on the same patient after.		4. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will conduct random audits twice weekly for four weeks and then four times monthly for two months observing glucometer cleaning. Results will be reviewed in Performance Improvement Committee meeting monthly for further recommendations.		

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F 441	<p>Continued From page 6</p> <p>contact with material that may contain a high concentration of microorganisms. The facility's policy further revealed that gloves are to be removed promptly after use, before touching non-contaminated items and environmental surfaces, and for staff to wash hands immediately to avoid transfer of microorganisms to other patients or environmental surfaces.</p> <p>1. Observations conducted on 07/31/12, at 5:35 PM, revealed Licensed Practical Nurse (LPN) #1 performed a fingerstick blood glucose for Resident A. LPN #1 was observed to remove the glucometer, disposable lancet, and alcohol prep pad from the medication cart, and then washed her hands, put on gloves, and obtained the blood sample from Resident A's finger. LPN #1 then removed the gloves and washed her hands. The LPN proceeded to perform a fingerstick blood glucose for Resident B at 5:40 PM (five minutes after she performed the same procedure for Resident A) using the same glucometer. However, based on observation, the LPN failed to clean/sanitize the glucometer after performing the blood glucose level for Resident A and failed to clean the glucometer before the blood glucose level was obtained for Resident B.</p> <p>Interview with LPN #1 on 07/31/12, at 6:25 PM, revealed she had been trained to clean/sanitize the glucometer with a bleach wipe before and after each resident use. The LPN confirmed she had not cleaned the glucometer when doing the blood sugar levels for Residents A and B and stated she "did not think about cleaning the glucometer today."</p> <p>Interview with the Director of Nurses (DON) on</p>	F 441	<p>Director of Nursing, Assistant Director of Nursing and/or Unit Managers will conduct random audits twice weekly for four weeks and then four times monthly for two months observing perineal care and skin assessments focusing on hand hygiene and glove changing, results will be reviewed in monthly Performance Improvement Committee meeting for further recommendations.</p> <p>5. Completion date: August 28, 201</p>		

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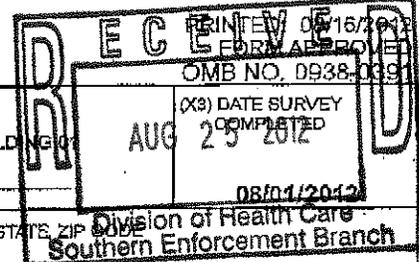
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F 441	Continued From page 7 07/31/12, at 7:05 PM, revealed all licensed nurses had been trained on proper cleaning/sanitizing of the glucometer machines. The DON confirmed staff was required to clean/sanitize the glucometer with a bleach wipe before and after each resident use. According to the DON, audits were conducted several times a month to monitor medication pass, which included observation of staff performance of blood glucose levels, and there had not been any problems identified. 2. Observation on 08/01/12, at 5:10 PM, revealed LPN #1 performed a skin assessment for Resident #3. During the skin assessment Licensed Practical Nurse (LPN) #1 assessed Resident #3's perineal area, touched the area with gloved hands, and then touched Resident #3's shirt and bed pressure alarm. Continued observation of the skin assessment revealed the LPN assessed/touched the resident's buttocks (with the same gloves), and then touched the resident's sheet, shirt, and blankets with the soiled gloves when she assisted the resident to reposition. Interview with LPN #1 on 08/01/12, at 5:30 PM, revealed she should have washed her hands and changed gloves after assessment of Resident #3's perineal area and prior to touching Resident #3's shirt and bed alarm. LPN #1 further stated she should have removed the gloves and washed her hands after assessment of the buttocks and prior to touching Resident #3's sheet, shirt, and blankets. Interview with the Director of Nursing (DON) on 08/02/12, at 4:00 PM, revealed hands must be	F 441		

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F 441	Continued From page 8 washed and gloves changed when assessing an area of the body with the potential for higher concentrations of contaminants to an area of the body with lesser concentration of contaminants to prevent cross-contamination and the spread of infection.	F 441			

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1986, 1996 Survey under: 2000 Existing Facility type: SNF/NF Type of structure: One story Type V(111) with partial basement Smoke Compartments: 4 Fire Alarm: Full fire alarm system installed in 1986	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Grant Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 052 SS=F	Sprinkler System: Automatic (dry) sprinkler system installed in 1986 Generator: Type II natural gas installed in 2010 A Life Safety Code survey was conducted on 08/01/12. Grant Manor Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 90. The facility is licensed for 95 beds. The following findings demonstrate noncompliance with the highest scope/severity at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052	K052 1. Fire alarm sensitivity testing was completed for the entire fire system on August 10, 2012 by FESCO fire suppression equipment contractor. 2. Center smoke detectors were inspected on August 10, 2012 by FESCO contractor and tested for their sensitivity to smoke. Center smoke detectors were determined to be functioning with several identified to be replaced. Smoke detectors identified for replacement were replaced on August 21, 2012 by the contractor.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 8/25/12

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K 052	Continued From page 1 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	3. The Administrator met with the Maintenance Director and reviewed the Life Safety Code requirement for sensitivity testing on August 2, 2012. The Maintenance Director added completion of the sensitivity testing to the TELS system, an automated system that alerts the center when routine maintenance is required on such equipment, on August 22, 2012. The TELS system will alert center Administrator and Maintenance Director when sensitivity testing is due to be completed on the fire alarm system. The Administrator and/or Maintenance Director will notify FESCO or other fire suppression equipment contractor that testing of the system is needed timely to ensure completed as necessary.	
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	<p>This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection record review, the facility failed to test and maintain the fire alarm system per NFPA standards. The deficiency had the potential to affect four of four smoke compartments, all residents, staff, and visitors. The facility is licensed for 95 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>Fire alarm inspection record review on 08/01/12, at 12:15 PM, with the Maintenance Director, revealed the facility failed to provide documentation to show the fire alarm sensitivity test had been completed. The last documented sensitivity test date was April 2010.</p> <p>Interview on 08/01/12, at 12:15 PM, with the Maintenance Director revealed he thought that</p>			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2012
NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	Continued From page 2 the sensitivity test had been completed. The findings were also confirmed with the Administrator at exit conference. NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052	4. The Administrator will review the TELS system monthly for 12 months to validate routine maintenance/testing is completed for fire alarm system per NFPA standards. The Maintenance Director and/or Administrator will report TELS system review monthly to the Performance Improvement Committee meeting for any further recommendations. 5. Completion date: August 28, 2012		