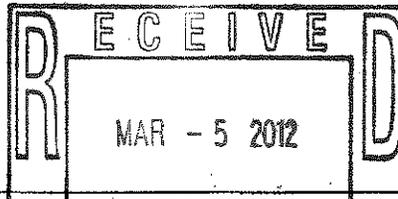


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>Division of Health Care Southern Enforcement Branch</u> B. WING: _____	(X3) DATE SURVEY COMPLETED 02/09/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977
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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 02/07-09/12. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	Mountain View Nursing & Rehab acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Mountain View Nursing & Rehab's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Mountain View Nursing & Rehab reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	<u>F 157</u> Resident #11 was appropriately assessed on 01/14/2012 by the licensed nurse. The MD & RP were notified on 01/14/2012. All residents have the potential to be affected. A QI audit of the progress notes for all current residents was completed on 02/26/12 by DON &	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly M. Gaudin ADMINISTRATOR TITLE: _____ 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.

0305-12

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to immediately notify the physician when there was an accident involving one of twenty-three sampled residents. Documentation revealed Resident #11 sustained a fall on 01/14/12, at 4:07 AM. However, there was no evidence the physician of Resident #11 was notified of the resident's fall until 10:00 AM, a timeframe of four hours and forty-two minutes after the fall occurred. In addition, the facility failed to notify Resident #11's responsible party of the resident's fall until 01/14/12, at 11:02 AM, a timeframe of five hours and forty-four minutes after the fall occurred. The findings include: A review of the facility policy titled "Notification of Changes" (dated February 2009) revealed the facility would notify the resident's physician and legal representative when an accident occurred which resulted in an injury and had the potential for requiring physician intervention. A review of the medical record for Resident #11 revealed the facility admitted the resident on 01/13/12, with diagnoses that included Alzheimer's Disease, Anxiety, and Depression. A review of a Quarterly Minimum Data Set (MDS) assessment dated 10/20/11, revealed Resident #11 had moderately impaired cognition and exhibited wandering behaviors. The MDS also revealed the resident required the extensive	F 157	<u>F 157 Con't</u> ADON to identify that the facility had notified the MD & RP for any change in resident condition over the past 30 days. Any issues identified as a result of the audit have been reported to the MD &/or RP. The MD & RP will continue to be notified promptly of any occurrences or changes in condition of the residents. Licensed nurses were re-educated on 02/09/2012 by QI Nurse regarding the importance of prompt notification of the MD and RP when there is an accident involving the resident which results in injury & has the potential for requiring MD intervention, a significant change in condition occurs, a need to alter treatment significantly, a decision is made to transfer or discharge the resident from the facility, when there is a change in room or roommate assignment or a change in resident rights occurs. New employees hired will receive this information during the orientation process. The Administrative Nurse assigned to each hall will continue to monitor the Daily 24 hour Report Sheet & will complete a QI chart audit 3 times each week to ensure prompt	

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F 157	<p>Continued From page 2 assistance of one person to transfer.</p> <p>A review of the comprehensive plan of care for Resident #11 with a revision date of 01/19/12, revealed the resident had been assessed by the facility to be at risk for falls and the facility had listed interventions that included to provide assistance to the resident as tolerated, and to assist the resident in bed to an upright position.</p> <p>Documentation provided by the facility revealed Resident #11 "rolled out of bed" on 01/14/12, at 4:07 AM, and was observed to have a "jump to the right forehead." Continued review of documentation in the medical record revealed at 4:18 AM on 01/14/12, staff noted the area to the resident's right forehead had a small opening; staff cleaned the area with normal saline and applied a Tegaderm dressing. There was no documentation that the resident's physician was notified of the resident's fall or of the area on the forehead at that time. In addition, documentation in the medical record revealed at 8:00 AM on 01/14/12, the resident was observed to have "swelling to the right side of the forehead, tiny scratch with Tegaderm." The documentation also revealed the resident's pupils were equal, reactive to light, and the resident had good grips bilaterally. Documentation at 9:00 AM on 01/14/12, revealed Resident #11 was "up ambulating about the facility and was agitated." Continued review of documentation revealed facility staff paged the physician at 9:00 AM, to inform him of the resident's condition and the physician returned the call to the facility at 10:00 AM, a timeframe of four hours and forty-two minutes after the resident's fall. Based on documentation, the physician requested for</p>	F 157	<p>F157 Con't</p> <p>MD/RP notification when occurrences or significant change in resident condition occurs. Any issues identified will be corrected at the time of review with appropriate MD/RP notification completed as indicated.</p> <p>The results of these audits will be reviewed with the DON & Administrator in the weekly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC & MDS nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3-25-12	

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F 157	<p>Continued From page 3</p> <p>Resident #11 to be sent to a hospital Emergency Department for evaluation. The documentation also revealed the responsible party for Resident #11 was notified on 01/14/12, at 11:02 AM, a timeframe of five hours and forty-four minutes after the resident sustained the fall.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #4 on 02/09/12, at 12:20 PM, revealed the LPN had notified both the responsible party and the physician of Resident #11's fall. The LPN stated she had been given the information in report that morning at the beginning of her shift and had monitored the resident. However, according to LPN #4, Resident #11 began to complain of neck and head pain, and the nurse "paged" the physician.</p> <p>An interview with LPN #3 on 02/09/12, at 2:50 PM, revealed the LPN provided care to Resident #11 at the time of the resident's fall on 01/14/12. The LPN stated she heard a sound, went to Resident #11's room, and discovered the resident had fallen out of bed. The LPN stated the resident sustained an abrasion over his/her eye. The LPN acknowledged she had not called the resident's physician or the resident's responsible party at the time of the fall, but asked the oncoming shift that morning to call the physician and the responsible party. The LPN stated, "I have been told to never call the physician or the responsible party unless it is an emergency and I did not feel it was an emergency because the resident did not appear to be injured that badly."</p> <p>An interview conducted with the Director of Nursing on 02/09/12, at 4:05 PM, revealed she was made aware facility staff had not notified the</p>	F 157			

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F 157	Continued From page 4 resident's physician and responsible party of the resident's fall until approximately 9:00 AM on 01/14/12. The DON stated the nurse should have notified the resident's physician and responsible party immediately after Resident #11 had fallen. According to the DON, after she was made aware of the resident's fall, the resident's physician was notified of the resident's condition at 10:00 AM, the resident's responsible party was notified at 11:00 AM, and the resident was sent to the Emergency Room for evaluation. The DON stated LPN #3 should have notified the physician and responsible party when Resident #11's fall initially occurred and not hours later.	F 157			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was maintained in a sanitary manner. Observations of the medication room on the West Wing revealed a soiled medication cart and a fan inside the medication room that was covered with dust. The findings include: An interview with the Quality Assurance (QA) Nurse on 02/09/12, at 4:50 PM, revealed the facility did not have a policy related to cleaning of	F 253	F 253 The West Wing medication cart and the fan inside the medication room were thoroughly cleaned on 02/09/2012 by the HSK Supervisor. An audit was completed on 02/09/2012 by QI Nurse of all medication & treatment carts to ensure each was maintained in a sanitary manner. Any areas found soiled were cleaned as necessary.		

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F 253	Continued From page 5 the medication room. However, according to the QA nurse, she monitored the medication rooms monthly for cleanliness and to check for expired medications. Observations of the West Wing medication room on 02/09/12, at 3:15 PM, revealed two drawers located inside the cart that were soiled and stained. There was a red, dried, sticky substance inside the drawer that contained liquid medications. The lower side drawer was observed to have a towel lining the bottom of the drawer and a dried, dark brown stain was observed on the towel. Further observations of the medication room revealed a portable fan that had a heavy buildup of dust on the fan blades, motor, and housing of the fan. An interview with the Certified Medication Technician (CMT) on 02/09/12, at 3:15 PM, revealed CMTs and nurses were to keep the carts clean. The CMT further stated she had not noticed the dried spills inside the cart and Environmental Services staff was responsible for cleaning the rest of the medication room and equipment. An interview with the Environmental Services Supervisor (ESS) on 02/09/12, at 3:45 PM, revealed the Environmental Services staff was responsible to clean the surfaces and equipment in the medication room and stated fans were to be cleaned once weekly.	F 253	F253 Con't Licensed nursing staff and KMAs were re-educated on 03/01/2012 by the DON regarding the expectation that the facility environment, including the medication & treatment carts is to be maintained in a sanitary manner. New employees hired will receive this information during the orientation process. Administrative Department rounds will be conducted 3 times each week by the facility Department Heads using the QI Rounds Tool to monitor that the facility environment, including the medication and treatment carts is being maintained in a sanitary manner. Any issues identified will be corrected at the time of the audit with further retraining to occur with staff as needed. The results of the QI Rounds Tools will be reviewed with the DON & Administrator in the weekly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the accompanying action will be reviewed monthly by the Executive QI committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC & MDS Nurses, with any further retraining or other such interventions implemented as necessary.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		3/25/12

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F 282	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, the facility failed to provide services in accordance with the resident's written plan of care for three of twenty-three sampled residents (Residents #3, #10, and #12). Record review revealed Resident #3 was to have bilateral palm protector splints (therapeutic devices to prevent worsening of present contractures) on in the mornings. However, observations conducted on 02/08/12 and 02/09/12, of Resident #3 revealed the therapeutic device had not been provided as ordered. Record review revealed Resident #10 was to receive assistance with meals; however, observations conducted during the evening meal on 02/07/12, revealed staff failed to provide assistance for Resident #10. Record review revealed Resident #12 was to receive assistance with meals and was to have a "nosey" drinking cup for each meal; however, observations conducted during the evening meal on 02/07/12, revealed these services were not provided for the resident.</p> <p>The findings include:</p> <p>A review of the facility's Resident Care Plan policy revealed the development and implementation of the care plan would occur by disciplines available in the facility at a team conference. However the</p>	F 282	<p>F 282</p> <p>Resident #10 was re-assessed on 02/08/2012 by ADON regarding the amount of assistance required with meals.</p> <p>Resident #12 was provided a nosey cup on 2/9/12 as ordered.</p> <p>Resident #3 was re-assessed on 02/08/2012 by ADON for the continued need for bilateral palm protectors. Any changes have been updated on the care plan &/or care guide as appropriate.</p> <p>All residents have the potential to be affected. The dining process was reviewed by the Administrator, DON & ADON & another seating time was added to the program on 2/16/12 to ensure all residents who needed assistance with meals could be taken to the dining room, monitored & provided the assistance needed as identified in their individual plan of care.</p> <p>Residents' with orders for assistive devices, including nosey cups was reviewed by the ADON on 02/16/2012 to ensure dietary was aware of the need for these devices & was providing them with meals as ordered.</p>		

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F 282	<p>Continued From page 7</p> <p>policy failed to specify how facility staff would ensure services outlined in the resident's plan of care were provided.</p> <p>1. A review of the medical record for Resident #10 revealed the facility admitted the resident on 12/03/08, with diagnoses of Dementia, Hypertension, and Depressive Disorder. A review of the comprehensive care plan revised on 09/08/11, for Resident #10 revealed the resident required assistance with eating due to the resident's history of poor intake and his/her decline in cognitive ability. Further review of Resident #10's plan of care revealed staff was to assist and praise Resident #10 for eating and was to encourage the resident to drink fluids often during meal times.</p> <p>Observations of Resident #10 conducted on 02/07/12, during the evening meal service revealed facility staff provided the resident with a meal tray at 5:20 PM. However, continued observations throughout the evening meal from the time the resident's tray was delivered at 5:20 PM, through 6:05 PM, revealed facility staff failed to provide assistance or encouragement to Resident #10 in accordance with the resident's written plan of care.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 02/07/12, at 6:05 PM, revealed she had delivered the evening meal trays for Resident #10 and stated the resident required assistance with eating. However CNA #1 acknowledged she failed to return to the resident to provide assistance. CNA #1 stated she was busy feeding other residents and had failed to report to the nurse that she was unable to assist Resident #10.</p>	F 282	<p><u>F282 Con't</u></p> <p>Residents receiving splinting devices, including palm guard protectors were reviewed on 02/16/2012 by the ADON to ensure these devices were being provided per the plan of care. Any discrepancies were corrected immediately. Residents will continue to have services provided in accordance with their written plan of care.</p> <p>An audit will be completed weekly by the ADON or designee comparing the care plan/care guide with the services being provided to ensure that identified needs are being met & that interventions are in place & being carried out consistently by the direct care staff. The results of the audits will be reviewed with the Administrator, & DON in the weekly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>		

3/25/12

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F 282	<p>Continued From page 8</p> <p>2. A review of the medical record for Resident #12 revealed the facility admitted the resident on 06/23/11, with diagnoses of Anemia, Weakness, and Dementia with behavioral disturbances. A review of the comprehensive care plan for Resident #12 revealed the resident required assistance with eating to maintain maximum functioning. According to the care plan, facility staff was to assist the resident with eating when the resident became sleepy or fatigued, and was to provide encouragement, cues, and assistance to finish meals. Continued review of the plan revealed the resident had been evaluated by a speech therapist on 02/02/12, and as a result of the evaluation the therapist recommended a "nosey" cup be provided to Resident #12 during meals to aid in the resident's oral intake.</p> <p>Observations of Resident #12 during the evening meal service on 02/07/12, revealed facility staff delivered a meal tray for the resident at 5:23 PM, arranged the tray on the resident's bedside table, removed the plate cover, and opened utensils and the resident's drink. Further observations revealed Resident #12's eyes were closed from 5:23 PM through 6:05 PM, and the resident made no attempts to eat the meal. Based on observation, facility staff failed to wake the resident for the meal or to provide Resident #12 assistance in accordance with the resident's plan of care. Further observations of Resident #12 during the evening meal on 02/07/12, lunch meal on 02/08/12, and lunch meal on 02/09/12, revealed the facility failed to ensure a "nosey" cup was provided during meal times as outlined in the plan of care for Resident #12.</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 02/07/12, at 6:05 PM, revealed she had set up the evening meal trays for Resident #12 and stated the resident required assistance with eating. CNA #1 acknowledged she had failed to return to Resident #12's room to provide the resident assistance with the meal. CNA #1 stated she was busy feeding other residents and failed to report to the nurse that she was unable to assist Resident #12 with his/her meal as required.</p> <p>An interview with RN #1 on 02/07/12, at 6:15 PM, revealed she was to monitor meal services to ensure services were provided as outlined in the resident's plan of care. However, RN #1 was unaware CNA #1 had failed to provide assistance during meals as care planned for Resident #10 or Resident #12.</p> <p>An interview with the Dietary Manager on 02/09/12, at 2:15 PM, revealed dietary staff provided "nosey" cups on meal trays to residents that required and had physician's orders for them. Further interview revealed staff had failed to inform the Dietary Manager that a "nosey" cup had been recommended for Resident #12.</p> <p>An interview with the Director of Nursing (DON) on 02/09/12, at 2:25 PM, revealed Resident #12 had a physician's order written on 02/04/12, for a "nosey" cup for use with meals and she had "signed off" on the order. Continued interview revealed the DON had failed to notify the Dietary Department of the physician's order for the "nosey" cup for Resident #12. Further interview with the DON revealed CNAs should assist Residents #10 and #12 with their meals as</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>outlined in their plan of care. The DON stated staff nurses were to supervise meal service to ensure facility staff provided assistance as needed to the residents during meal times.</p> <p>3. A review of the medical record for Resident #3 revealed the facility admitted the resident on 12/15/09, with diagnoses of Chronic Obstructive Pulmonary Disease, Arteriosclerotic Heart Disease, Anxiety, Rheumatoid Arthritis, Contracted Hands, and Chronic Pain.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 11/24/11, revealed Resident #3 was totally dependent for transfers, dressing, and toilet use, and required extensive assistance for bed mobility, eating, and personal hygiene. Resident #3 was further assessed to have functional limitation in range of motion to the upper extremities, bilaterally. A review of the Plan of Care for Resident #3 revealed the resident required assistance to maintain maximum function for mobility and was at risk for worsening of present contractures. According to the plan of care, staff was responsible to apply bilateral palm protector splints for six hours daily six days a week. The splints were to be applied after breakfast and removed after lunch.</p> <p>Observations on 02/08/12, at 8:00 AM and 10:30 AM, and on 02/09/12, at 9:00 AM, revealed the bilateral palm splints were not in use for Resident #3.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 02/09/12, at 9:25 AM, revealed the Restorative Nurse Aide had been responsible to apply and remove the splints and</p>	F 282			

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F 282	Continued From page 11 had documented on 02/08/12, at 1:34 PM, that the splints had been removed. The ADON stated it was her responsibility to monitor the Restorative Nurse Aide; however, the ADON stated she had not actually observed whether the splints were in place for Resident #3 during the times specified.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services for one of twenty-three sampled residents (Resident #12). Record review for Resident #12 on 02/09/12, revealed the Registered Dietitian (RD) made recommendations on 01/19/12, for the resident's physician to be contacted related to observations of daytime drowsiness and a possible need for medication adjustments. The findings include: An interview with the Director of Nursing (DON) on 02/09/12, at 2:25 PM, revealed the facility did not have a policy related to recommendations made by the Registered Dietitian. Record review revealed the facility admitted	F 309	F 309 Resident #12 was re-assessed on 02/08/2012 by DON for daytime drowsiness & the MD was notified of the possible need for medication adjustments. All residents have the potential to be affected. An audit of RD recommendation completed in the last 30 days was completed on 02/13/2012 by DON. Any identified concerns were addressed immediately as appropriate including MD notification. The facility will continue to provide the necessary care & services including addressing RD recommendations in a timely manner & notification of the MD for evaluations for possible medication adjustments as indicated.	

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F 309	<p>Continued From page 12</p> <p>Resident #12 on 06/23/11, with diagnoses of Dementia with Behavioral Disturbances, Anemia, Chronic Kidney Disease, and Weakness. A review of the comprehensive care plan dated 11/22/11, and a Quarterly Minimum Data Set (MDS) Assessment dated 12/29/11, revealed the resident required total assistance with transferring, dressing, and bathing. Further review of the comprehensive care plan revealed facility staff had addressed a focus area for Resident #12 to be "in a state of nourishment, less than body requirements characterized by weight loss, inadequate intake, and decreased appetite." Continued review of Resident #12's comprehensive care plan revealed facility staff had assessed the resident to require assistance during meals due to deficits in the resident's cognition, and the tendency of Resident #12 becoming sleepy and or fatigued during meal times.</p> <p>A Review of the Registered Dietitian's (RD) progress notes dated 01/19/12, revealed the RD assessed Resident #12 on 01/19/12, at 8:58 AM, to be "in a geri-chair and very drowsy." Based on the RD's assessment, Resident #1 had a 3.4 percent weight loss during the 30-day timeframe prior to the RD's assessment. Further review of the RD progress notes revealed the RD had recommended the physician be contacted to possibly adjust medication dosage times due to Resident #12's increased drowsiness during the day.</p> <p>A review of the nurse's notes in Resident #12's medical record was conducted on 02/09/12, and revealed no evidence facility staff had contacted Resident #12's physician as recommended by the</p>	F 309	<p><u>F 309 Con't</u></p> <p>The DON was re-educated on 2/28/12 by the facility nurse consultant on ensuring care & services are provided including timely follow up of RD recommendations & documentation of MD notification of RD recommendations in the resident's medical record.</p> <p>A weekly QI audit will be conducted by the DON to ensure that the MD is notified of RD recommendations & that documentation is completed in the resident's medical record. The results of the QI audits will be reviewed by the DON & Administrator in the weekly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, and MDS Nurses monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 309	Continued From page 13 RD on 01/19/12, a timeframe of 21 days. Observations of Resident #12 on 02/07/12, during the evening meal revealed the resident's meal tray was delivered at 5:20 PM, and the resident was asleep. Further observations on 02/07/12, revealed the resident continued to sleep through the evening meal until the last observation at 6:45 PM on 02/07/12. At that time, the resident's meal tray remained, uneaten, at the resident's bedside. An interview with the Director of Nursing (DON) on 02/09/12, at 2:15 PM, confirmed facility staff failed to contact Resident #12's physician as recommended by the RD on 01/19/12. Continued interview with the DON revealed nurses were responsible to follow through with dietary recommendations when they were received. Further interview with the DON revealed she was responsible to ensure RD recommendations were completed for the residents.	F 309			
F 325 SS=D	483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325	F 325 Resident #10 and Resident #12 were re-assessed on 02/08/2012 by ADON for the amount of assistance required with their meals.		

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F 325	<p>Continued From page 14</p> <p>by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions consistent with the resident's comprehensive assessment and the resident's needs were implemented to maintain the nutritional status for two of twenty-three sampled residents (Residents #10 and #12). A review of documentation in the medical record revealed Resident #10 and Resident #12 require assistance with meals. However, observations conducted during the evening meal on 02/07/12, revealed facility staff failed to provide Resident #10 and Resident #12 assistance with their meals as identified in the comprehensive assessment.</p> <p>The findings include:</p> <p>A review of the facility policy entitled Feeding of Residents revealed the facility failed to provide staff procedures to follow to ensure residents that had been assessed to require assistance with meals received the assistance in accordance with their assessments and in a timely manner.</p> <p>1. Review of the medical record for Resident #10 revealed the facility admitted the resident on 12/30/08, with diagnoses that included Dementia, Hypertension, and Gastritis. Review of an Annual Minimum Data Set (MDS) assessment dated 12/01/11, revealed the resident required extensive assistance with bed mobility, dressing, and supervision during meal times.</p> <p>Review of the comprehensive care plan dated 09/08/11, for Resident #10 revealed facility staff had assessed the resident to require assistance with eating. Continued review of the plan</p>	F 325	<p>F325 Con't</p> <p>All residents have the potential to be affected. The dining process was reviewed by the Administrator, DON & ADON & another seating time was added to the program on 2/16/12 to ensure all residents who needed assistance with meals could be taken to the dining room, monitored & provided the assistance needed as identified in their individual plan of care. Residents will continue to receive assistance with meals as needed to maintain nutritional status.</p> <p>Staff re-education was completed on 02/16/2012 by ADON on the new dining seating time & on providing assistance as identified on the resident's care guide during meal service.</p> <p>A QI audit will be conducted weekly by QI Nurse or designee to identify that each resident receives the assistance as identified on the resident's care guide during meals. Any identified concerns will be corrected immediately. The results of the QI audits will be reviewed by the DON & Administrator in the weekly QI Committee meeting. Any further</p>		

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F 325	<p>Continued From page 15</p> <p>revealed Resident #10 required cues and reminders to eat and finish meals secondary to a progressive decline in his/her cognitive ability. Facility staff developed interventions to be used at Resident #10's meal time which directed staff to assist the resident with his meal when the resident became fatigued. In addition, staff was to encourage the resident to drink fluids "often" at the meal.</p> <p>Certified Nurse Aide (CNA) #1 was observed to deliver the evening meal to Resident #10 on 02/07/12, at 5:20 PM.</p> <p>Observations of Resident #10 on 02/07/12, at 5:20 PM, revealed the resident was lying in bed with the head of the bed elevated to a sitting position with eyes open. CNA #1 was observed to place Resident #10's evening meal tray on the bedside table and positioned the table, with the plate cover removed, and utensils and drinks opened, in front of the resident. However, the CNA failed to provide the resident assistance with the meal at that time. Continued observations from 5:20 PM through 6:05 PM, revealed facility staff failed to provide Resident #10 assistance with the meal as planned in the resident's care plan.</p> <p>2. Review of the medical record for Resident #12 revealed the facility admitted the resident on 06/23/11, with diagnoses of Dementia with behavioral disturbances, Anemia, and Chronic Kidney Disease. A Quarterly Minimum Data Set (MDS) Assessment dated 12/29/11, revealed Resident #12 required extensive assistance with meals.</p>	F 325	<p>F325 Con't</p> <p>actions needed will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 325	<p>Continued From page 16</p> <p>Review of the comprehensive care plan dated 11/22/11, for Resident #12 revealed the resident required assistance with meals. Continued review of Resident #12's care plan revealed staff was to provide encouragement and cues and assist Resident #12 with his/her meal if the resident became sleepy and/or fatigued. In addition, staff was to feed the resident if the resident was unable to complete the meal.</p> <p>Observations of the evening meal on 02/07/12, revealed Certified Nurse Aide (CNA) #1 delivered the meal tray for Resident #12 at 5:23 PM.</p> <p>Observation of Resident #12 on 02/07/12, at 5:23 PM, revealed the resident was in bed, with eyes closed, and the head of the bed was observed to be elevated to a sitting position. CNA #1 was observed to place Resident #12's evening meal tray on the bedside table, remove the plate covers, and open the utensils and drinks, but failed to provide assistance at the time the meal was delivered. Continued observations from 5:20 PM until 6:05 PM, revealed Resident #12's eyes remained closed during the evening meal time, and facility staff failed to cue the resident to eat or provide the resident assistance as outlined in the resident's plan of care.</p> <p>An interview with CNA #1 on 02/07/12, at 6:05 PM, confirmed she delivered the meal trays, removed the plate covers, and opened utensils and drinks for Residents #10 and #12. Further interview with CNA #1 revealed Residents #10 and #12 were "follow-up feeders" and needed assistance of being reminded, encouraged, and at times required to be fed by staff during meal times. At the time of the interview, 6:05 PM, CNA</p>	F 325			

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F 325	<p>Continued From page 17</p> <p>#1 acknowledged she had not returned to Resident #10 or Resident #12 after their meal trays had been delivered at 5:20 PM, a timeframe of 45 minutes, to assist with their meals. Further interview with CNA #1 revealed she had other residents to feed, and had not had time to return and provide assistance to Resident #10 or Resident #12. However, CNA #1 stated she had failed to notify any other staff members of her inability to assist Resident #10 or Resident #12 with their evening meal on 02/07/12.</p> <p>An interview on 02/07/12, at 6:15 PM, with RN #1 revealed she was assigned to ensure care needs were met for Residents #10 and #12. Continued interview with RN #1 revealed she was to ensure residents received assistance during meal service by making walking rounds. However, RN #1 was unaware facility staff had failed to provide assistance with the evening meal for Resident #10 and Resident #12 after their trays had been delivered to their rooms, a timeframe of 45 minutes. RN #1 stated she had not been notified by CNA #1 of her inability to assist Resident #10 or Resident #12 during the evening meal service on 02/07/12.</p> <p>An interview with the Director of Nursing (DON) on 02/07/12, at 6:20 PM, revealed it was the responsibility of facility staff nurses to supervise meal service and ensure residents received assistance as outlined in their plan of care. Continued interview with the DON revealed Residents #10 and #12 should have been provided assistance by facility staff during the evening meal on 02/07/12.</p>	F 325			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	Continued From page 18 Each resident's drug regimen must be free from unnecessary drugs: An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of policy, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs and/or failed to adequately monitor medications for two of twenty-three sampled residents (Residents #3 and #13). Resident #3 received Atarax without adequate indications for use and Resident #12 received Depakote with no evidence of monitoring to	F 329	F 329 Resident #3 the MD was notified on 02/09/2012 by DON & a clarification order was received for the diagnosis for use. Resident #13 the MD was notified on 02/09/2012 by ADON & an order was received for depakote lab level. All residents have the potential to be affected. Resident medication regimen review was completed for current residents by the Pharmacy Consultant on 03/01/2012 to re-evaluate medications, including atarax & depakote, for adequate indications for use, effectiveness, & that appropriate dose reductions have been attempted. This review also included ensuring that any residents receiving medications that required therapeutic monitoring had MD orders for routine monitoring of therapeutic drug levels. Resident medication regimens will continue to be reviewed on admission & at least quarterly by the pharmacy consultant to ensure that resident's		

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F 329	<p>Continued From page 19 ensure therapeutic levels of the medication.</p> <p>The findings include:</p> <p>A review of the facility's "Consultant Pharmacist's Responsibility" policy/procedure (no date given) revealed the consultant pharmacist was responsible to ensure medication orders were complete including drug name, strength, dose, route, frequency, indications for use, and special instructions if indicated. In addition, the pharmacist was to suggest appropriate monitoring when indicated. The consultant pharmacist was to prepare his/her report and send it to the facility's Administrator and Director of Nursing (DON). The DON was responsible to review this report and document actions taken as the result of the consultant pharmacist's recommendations.</p> <p>1. A review of the medical record for Resident #3 revealed the resident was admitted to the facility on 12/15/09, with diagnoses that included Arteriosclerotic Heart Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Anxiety, Rheumatoid Arthritis, and Cancer of the Lung.</p> <p>A review of Physician Progress Notes, dated 08/29/11, revealed Resident #3 complained of "itching." A review of physician's orders dated 08/30/11, revealed the physician prescribed 10 milligrams (mg) of Atarax (a medication used for itching from allergies, to control nausea and vomiting, and for mild anxiety) to be administered to Resident #3, three times a day, due to the resident's complaint of itching. Continued review of physician's orders revealed the physician continued to prescribe Atarax to Resident #3 and</p>	F 329	<p><u>F329 Con't</u></p> <p>drug regimen remain free of any unnecessary drugs. Any concerns were addressed immediately as indicated.</p> <p>Licensed nursing staff was re-educated on 03/01/2012 by the Licensed Pharmacy Consultant in following facility protocol to ensure that there is an appropriate diagnosis for use of each medication ordered & that resident's receiving medications that require therapeutic monitoring have an order for routine lab levels to be drawn.</p> <p>A monthly QI will be completed by the ADON to ensure that any medications ordered will have a diagnosis for use identified and that medications requiring therapeutic monitoring, including depakote, have an order for routine monitoring of levels as indicated. The results of these audits will be reviewed with the Administrator & DON in the monthly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the</p>		

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F 329	<p>Continued From page 20</p> <p>based on documentation in the medical record on 02/08/12, Resident #3 had received the 10 mg of Atarax three times a day since 08/30/11, a timeframe of approximately five months.</p> <p>A review of the Drug Regimen Review by the facility's consultant pharmacist revealed on 11/16/11, the pharmacist's recommendations to the physician included changing Resident #3's Atarax from three times day, on a routine basis, to an "as needed" or "PRN" basis. There was no evidence the pharmacist identified the indications for use of the Atarax as specified in the policy. A review of the pharmacist's drug regimen review for Resident #3 revealed on 12/11/11, the physician declined the pharmacist's recommendation to change the Atarax 10 mg to a PRN order.</p> <p>Observations on 02/07/12, at 11:00 AM, revealed Resident #3 was sitting on the side of the bed and appeared to be drowsy and at 4:15 PM, the resident was observed to be asleep in bed. On 02/08/12, at 8:00 AM, Resident #3 was observed sitting on the side of the bed and on 02/09/12, at 9:00 AM, the resident was in bed sleeping. During the observations, Resident #3 was not observed to scratch his/her skin or complain of itching.</p> <p>An interview with the Director of Nursing (DON) on 02/08/12, at 5:15 PM, revealed the DON did not know why the physician had declined to accept the pharmacist's recommendation. According to the DON she documented "Declined" on the pharmacist's report and was unable to recall why there was no further documentation. The DON further stated she had</p>	F 329	<p>F 329 Con't</p> <p>accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 329	<p>Continued From page 21</p> <p>spoken with the Advanced Practice Registered Nurse (APRN) that was in practice with Resident #3's physician and the APRN thought the Atarax was for the treatment of Resident #3's behaviors and was unsure why the physician had refused to change the frequency.</p> <p>It could not be determined by a review of Resident #3's medical record or interviews with staff what specific condition Atarax had been prescribed to treat or that the facility had monitored the use of the medication.</p> <p>2. Record review revealed the facility admitted Resident #12 on 06/23/11, with diagnoses of Dementia with Behavior Disturbances, Seizure Disorder, and Chronic Kidney Disease. A review of a Quarterly Minimum Data Set Assessment (MDS) dated 12/29/11, revealed the facility assessed the resident to be moderately impaired with daily decision-making skills. Further review of the MDS revealed Resident #12 required total assistance from staff for transfers and personal hygiene.</p> <p>A review of Resident #12's medical record on 02/09/12, revealed on 06/29/11, the physician prescribed 500 mg of Depakote (an anticonvulsant) to be administered twice a day to the resident related to the resident's diagnosis of Seizure Disorder. A review of Resident #12's Medication Administration Record (MAR) revealed Resident #12 received 500 mg of Depakote twice a day since 06/29/11, a timeframe of approximately seven months. Further review of the resident's record revealed no evidence that a Depakote level had been obtained to ensure Resident #12 maintained a</p>	F 329			

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F 329	Continued From page 22 therapeutic dose of the medication, as recommended by the National Library of Medicine. Interview with the Assistant Director of Nursing (ADON) on 02/09/12, at 5:00 PM, confirmed the facility had failed to obtain Depakote levels to ensure Resident #12 maintained a therapeutic level of the medication.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure the medication error rate was not five percent or greater. During a medication observation conducted on 02/08/12, at 1:30 PM, a total of forty medication opportunities were observed with two medication errors identified that affected one unsampled resident (Resident #23). As a result of the errors, the facility's medication error rate was determined to be five percent. The findings include: A review of the facility policy titled "Medication Administration" (no date) revealed any deviation from the following principles would be considered a medication error: the right resident, right medication, right dose, right route, right method,	F 332	F 332 Resident #23 was assessed on 02/08/2012 by the licensed nurse with no signs/symptoms of adverse drug effects. The MD was notified & an order received to obtain a dilantin level the next morning. LPN #5 was immediately re-educated on 02/09/2012 by the DON on proper administration of medications including dilantin. Licensed staff & medication assistants have been re-educated on 03/01/2012 by the Licensed Pharmacy Consultant on medication pass techniques & administration medications, including dilantin as ordered. Medication pass audits will be continue to be completed by the Pharmacy Consultant & Staff Development Coordinator on Licensed Nursing Staff & KMAs at least annually to ensure appropriate administration of medications as ordered.	

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F 332	<p>Continued From page 23 and the right time. The policy also revealed the Medication Administration Records (MARs) would be checked on a regular basis to ensure continued and constant accuracy.</p> <p>A review of "Nursing 2008 Drug Handbook" published by Lippincott, Williams, and Wilkins, page 449, revealed due to the potential of enteral feedings interfering with the absorption of Dilantin (anticonvulsant) enteral feedings should be stopped for two hours before and two hours after the administration of Dilantin.</p> <p>A review of the medical record for Resident #23 revealed a physician's order for 100 mg (milligrams) of Dilantin Suspension 125 mg/5 ml (milliliters) to be administered three times a day by means of the resident's gastrostomy tube. The Dilantin Suspension was observed to be provided in measurements of 125 mg of medication in each 5 ml of liquid suspension. In order to administer the dosage of the Dilantin prescribed by the physician, staff would need to administer 4 ml of the Dilantin suspension, the equivalent of 100 mg of the medication, three times a day.</p> <p>Observation of medication administration on 02/08/12, at 1:30 PM, revealed Licensed Practical Nurse (LPN) #5 obtained a bottle of Dilantin Suspension 125 mg/5 ml and poured approximately 5 ml of the suspension into a plastic medication cup which measured in increments of 5 ml. The LPN then took the medication into Resident #23's room and stopped the resident's gastrostomy tube feeding. The LPN was then observed to check for tube placement with air, flush the tube with 30 ml of</p>	F 332	<p><u>F332 Con't</u></p> <p>Random med pass audits of 20% of licensed staff will be performed by the Pharmacy Consultant and/or Staff Development Coordinator monthly to ensure consistent med pass technique with an error rate at 5% or less. The results of the med pass audits will be reviewed with the Administrator & DON in the monthly QI Committee meeting. Any further actions needed will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 332	Continued From page 24 water, administer the Dilantin Suspension, flush the tubing with another 30 ml of water, and then restart the enteral tube feeding. The enteral tube feeding was observed to be Glytrol 1.0 infusing by a tube feeding pump at 60 ml per hour. An interview conducted with LPN #5 on 02/08/12, at 1:45 PM, revealed she was aware Resident #11 was to receive 100 mg of Dilantin as prescribed by the resident's physician. The LPN stated she always tried to go just a little under the 5 ml line. The LPN stated, "I probably should have used a syringe to measure the Dilantin." The LPN also stated she had been told by the facility it was no longer necessary to hold enteral feedings prior to and after the administration of Dilantin. An interview conducted with the Director of Nursing (DON) on 02/08/12, at 5:55 PM, revealed the nurse should have used a syringe to accurately measure the Dilantin Suspension. The DON also stated she had no documentation from the manufacturer stating it was a safe practice to administer Dilantin without holding the gastrostomy tube feeding prior to and after administration of the medication. The DON also stated medication administration audits were performed randomly and every nurse or medication aide was observed at least once a year and no issues had been identified.	F 332			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	F 333 Resident #23 was assessed on 02/08/2012 by the licensed nurse with no signs/symptoms of adverse drug effects noted. The MD was notified & an order received to obtain a dilantin level the next morning.		

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F 333	<p>Continued From page 25</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 ensure one of twenty-three sampled residents (Resident #23) was free from any significant medication errors. Resident #23 had a physician's order for 100 milligrams of Dilantin Suspension to be administered three times a day by means of the resident's gastrostomy tube. The Dilantin Suspension was observed to be provided in measurements of 125 milligrams of medication in each 5 milliliters of liquid suspension. In order to administer the dosage of the Dilantin prescribed by the physician, staff would need to administer 4 milliliters of the Dilantin suspension, the equivalent of 100 milligrams of the medication, three times a day. However, observation of medication administration on 02/08/12, revealed Licensed Practical Nurse (LPN) #5 obtained a bottle of Dilantin Suspension, 125 milligrams of medication per 5 milliliters of suspension, poured approximately 5 milliliters of the suspension into a plastic medication cup, and administered the medication to the resident.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Medication Administration" (no date) revealed all persons administering medication should always ensure they have the right resident, the right medication, the right dose, the right route, the right method, and the right time.</p> <p>A review of the medical record for Resident #23 revealed the resident's diagnoses included a</p>	F 333	<p>F 333 Con't</p> <p>LPN #5 was immediately re-educated on 02/09/2012 by the DON on proper administration of medications including dilantin.</p> <p>Licensed staff & medication assistants have been re-educated on 03/01/2012 by the Licensed Pharmacy Consultant on medication pass techniques & administration medications, including dilantin, as ordered. Newly hired licensed nurses & KMAs will receive this information during the orientation process.</p> <p>Random Med Pass Audits of at least a minimum of 5 licensed nurses and/or KMAs will be performed by the Pharmacy Consultant and/or Staff Development Coordinator monthly to ensure consistent med pass technique with an error rate at 5% or less. Re-education will be provided at that time if indicated. The results of the med pass audits will be reviewed with the Administrator & DON in the monthly QI Committee meeting. Any further actions needed, will be taken as</p>		

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F 333	<p>Continued From page 26</p> <p>history of seizure activity. Documentation in the medical record revealed a physician's order for 100 milligrams (mg) of Dilantin Suspension (anticonvulsant) to be administered to Resident #23 three times daily by gastrostomy tube. A review of the laboratory reports for Resident #23 revealed a Dilantin level had been obtained on 01/09/12, and revealed the resident's level was "11.6" (10.0 to 20.0) and was within normal limits.</p> <p>On 02/08/12, at 1:30 PM, a medication administration was observed and revealed Licensed Practical Nurse (LPN) #5 administered Dilantin Suspension (anticonvulsant) to Resident #23 through the resident's gastrostomy tube. The Dilantin Suspension was observed to be provided in measurements of 125 mg of medication in each 5 ml of liquid suspension. The LPN was observed to pour approximately 5 milliliters of the Dilantin Suspension into a plastic medication cup which contained measurements in increments of 5 ml and administered the Dilantin Suspension to Resident #23. Based on observation, the nurse administered a dosage of 125 mg of the medication in 5 ml of the Dilantin Suspension, instead of the 100 mg of Dilantin Suspension prescribed by the physician.</p> <p>LPN #5 acknowledged in an interview conducted on 02/08/12, at 1:45 PM, that she was aware the physician's order was for Resident #23 to receive 100 mg of Dilantin Suspension. However, the LPN stated she tried to measure the dosage of medication "just a little under" the 5 ml line on the medication cup. The LPN stated, "I probably should have used a syringe to measure the Dilantin" to ensure the dosage of the medication was accurate.</p>	F 333	<p><u>F333 Con't</u></p> <p>necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other no expired medications or undated vials such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 333	Continued From page 27	F 333		
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide foods to the West Wing that were palatable and attractive during the evening meal on 02/07/12.</p> <p>The findings include:</p> <p>An interview conducted with the Dietary Manager (DM) on 02/07/12, at 5:55 PM, revealed the facility did not have a policy related to the temperatures of food at the point of delivery or the desired timeframe for meal delivery.</p> <p>Observations of the evening meal service on 02/07/12, at 5:15 PM, revealed meals were</p>	F 364	<p>F 364 Re-education was completed with dietary staff on 02/16/2012 by Dietary Manager to include proper seasoning & garnishment of meal trays. Re-education was completed with licensed nursing staff on 02/07/2012 by SDC on ensuring meal trays were passed within a timely manner to maintain appropriate serving temperatures of foods. Food temperatures will continue to be checked a minimum of twice per meal by the Cook & temperatures adjusted as needed.</p>	

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F 364	<p>Continued From page 28</p> <p>delivered from the kitchen in a closed, unheated cart to the West Wing of the facility. At 5:22 PM, a second closed, unheated cart was delivered to the unit. At 5:50 PM, 28 minutes after the second food cart arrived on the floor, one tray remained on the cart. Temperatures were obtained and a food palatability test was performed on the remaining tray. The temperatures and food palatability tests revealed the cheeseburger macaroni tasted bland and was lukewarm at a temperature of 111 degrees Fahrenheit and the okra tasted lukewarm at 108 degrees Fahrenheit. The nectar-thickened milk tasted warm at 49 degrees Fahrenheit.</p> <p>An interview with the Dietary Manager (DM) on 02/07/12, at 6:00 PM, revealed the DM selected a meal tray to be tested every day at the lunch meal but had not tested an evening meal tray. The DM stated she had not identified a problem related to food temperatures, palatability, or the delivery of the meals to the residents timely. The DM further stated staff should call the kitchen to replace residents' trays after 15 to 20 minutes on the floor; however, the DM stated she was not aware of any in-services to train staff regarding this.</p> <p>An interview with State Registered Nurse Aide (SRNA) #3 at 6:05 PM on 02/07/12, revealed trays were not delivered timely because there had been only two SRNAs available on the floor to deliver the trays. SRNA #3 stated there should be three SRNAs to deliver meal trays to the residents' rooms and one SRNA to assist residents in the dining room, however, there were only two SRNAs assisting residents in their rooms on the day of the observation, 02/07/12.</p>	F 364	<p><u>F 364 Con't</u></p> <p>The Dietary Manager will complete a weekly Resident Satisfaction QI survey of a random sample of 20% current residents to ensure that foods served to residents are palatable, attractive & served at the appropriate temperatures. The results of these audits will be reviewed in the monthly QI Committee meeting with the Administrator & DON. Any further actions needed, will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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F 364	Continued From page 29 An interview with SRNA #1 on 02/07/12, at 6:05 PM, revealed trays should not sit for longer than 20 minutes before a replacement tray was obtained. According to SRNA #1, it usually took 12 to 15 minutes to serve trays when there were three SRNAs on the unit, but stated on the day of the observation, 02/07/12, there had not been adequate staff to assist residents with meals. An interview with Licensed Practical Nurse (LPN) #2 on 02/07/12, at 6:08 PM, revealed nurses monitored trays for timely delivery to ensure the food temperatures remained acceptable. According to LPN #2, nurses were also to assist SRNAs with serving trays. However, LPN #2 stated she was unaware of the time when food carts arrived on the floor and acknowledged that she had been on the telephone with a physician and resident family members at the time the trays were delivered.	F 364			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	<u>F 431</u> Identified insulin vials were immediately discarded when identified & new vials were obtained from the pharmacy. Medication rooms & refrigerators were audited on 2/9/12 by the DON to ensure no other expired or undated medications were available for use.		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
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F 431	Continued From page 30 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles. Observations of the East Wing medication room revealed one vial of insulin was not labeled with the date opened and one additional vial of insulin had exceeded the facility policy's expiration date and both were available for resident use. Observations of the West Wing medication room revealed one vial of insulin that exceeded the facility policy's expiration date and was available for resident use. The findings include: A review of the facility's Medication Expiration	F 431	F431 Con't Licensed nursing staff & KMAs were re-educated by the Licensed Pharmacy Consultant on 03/01/2012 regarding proper medication pass technique, including storage of insulin. Re-education included checking of expiration dates prior to administration of medications. A QI audit will be completed weekly by the QI nurse to ensure of insulin are available for use. The results of these audits will be reviewed in the weekly QI Committee meeting with the Administrator & DON. Any further actions needed, will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, DON, ADON, QI Nurse, Treatment Rounds tool to review that appropriate control measures are being followed to prevent the spread Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary. March 25, 2012	3/25/12

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F 431	<p>Continued From page 31</p> <p>Date Policy/Procedure (no date given) revealed, "All multi-dose vials of injectable medications shall be dated by staff at the time the seal is broken and the first dose drawn." In addition, the policy revealed insulin vials expired 28 days after opened.</p> <p>Observation on 02/09/12, at 3:15 PM, of the East Wing medication room revealed one vial of insulin that was opened and available for resident use. However, staff failed to document the date the medication was opened/accessed. Additional observation on 02/09/12, revealed an additional vial of insulin that, according to the date, had been opened on 12/18/11.</p> <p>Observations of the West Wing medication room on 02/09/12, at 3:30 PM, revealed one vial of insulin that, according to the documented date, had been opened on 01/06/12, and continued to be available for resident use six days past the expiration date established by the facility.</p> <p>An interview with Registered Nurse (RN) #2 at 3:30 PM, revealed nurses were responsible to document the date opened on all multi-dose medication vials/bottles. RN #2 further stated that night shift staff was responsible for monitoring the medications.</p> <p>An interview with the Quality Assurance (QA) nurse conducted on 02/09/12, at 4:50 PM, revealed she checked the medication rooms/carts once a month to check for cleanliness and to audit opened medications to ensure dates were included. The QA nurse further stated she had last checked the medication rooms/carts around the second week of January, approximately one</p>	F 431			

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F 431	Continued From page 32	F 431			
F 441 SS=D	month prior to the date of the interview. 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; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 SRNA #2 was immediately re-educated on 02/07/2012 by the SDC on the proper Infection Control precautions related to Resident #3. All residents have the potential to be affected. Re-education was immediately initiated by the Staff Development Coordinator for facility staff on 02/07/2012 regarding proper procedures related to infection control procedures for current residents with orders for increased precautions and/or isolation and continued until all facility staff have been re-educated. Newly hired employees will receive this information during the orientation process. The Staff Development Coordinator will conduct additional re-training when a new resident receives an order for increased precautions and/or isolation.		

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F 441	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an infection control program to ensure a safe, sanitary environment and to help prevent the development and transmission of disease and infection for one of twenty-three sampled residents (Resident #3). Resident #3 had physician's orders for Contact Precautions, however, the facility failed to ensure staff was knowledgeable of the precautions needed and staff failed to implement the appropriate precautions. The findings include: A review of the facility's infection control policy (dated August 2005) revealed the facility utilized Standard Precautions for all residents when providing care, regardless of the diagnosis or suspected infection. In addition to Standard Precautions, the facility utilized Transmission-based Precautions for residents as indicated. According to the policy, Contact Precautions were to be used in addition to Standard Precautions for residents known or suspected to have microorganisms that were easily transmitted by direct or indirect contact. Examples listed for Contact Precautions included Methicillin Resistant Staph Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), and conditions such as Conjunctivitis. The policy also directed staff to wear gloves, gown, and containment of the microorganism for Contact	F 441	<u>F441 Con't</u> Infection Control Rounds will be conducted monthly by SDC using the Facility Infection Control of infection in the facility. Any identified concerns will be addressed immediately. The results of these rounds will be reviewed with the Administrator & DON in the monthly Infection control Meeting. Any further actions needed, will be taken as necessary. Trends & the accompanying action will be reviewed by the Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, monthly with any further retraining or other such interventions implemented as necessary. March 25, 2012	3/25/12

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F 441	<p>Continued From page 34</p> <p>Precautions. In addition, according to the policy, a private room was preferred, but co-horting of residents was allowed. The resident's door could remain open and the site of infection was to be contained or covered before the resident was transported out of the room. The sign for Contact Precautions was to be placed on the resident's room door with instructions such as: "Visitors must report to Nursing Station Before Entering, Wash hands after every resident contact, Gloves when entering the room, Wear a gown if you anticipate that your clothing may become contaminated.</p> <p>A review of the medical record revealed the facility admitted Resident #3 on 12/15/09, with diagnoses that included Cancer of the Lung, Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, Anxiety, and Hypertension.</p> <p>A culture of Resident #3's eye was obtained on 01/27/12, and results were received on 01/30/12. The results indicated Resident #3 had an eye infection that was identified to be MRSA. The physician was notified, orders were received, and contact precautions were initiated.</p> <p>Observation on 02/07/12, at 11:10 AM, revealed the Contact Precautions sign was posted on the door of Resident #3's room. However, observation revealed State Registered Nurse Aide (SRNA) #2 adjusted the resident's oxygen tubing and attempted to feed Resident #3. SRNA #2 was observed feeding the resident without wearing any gloves or additional personal protective equipment (PPE) as required by the facility's Contact Isolation precautions.</p>	F 441			

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F 441	Continued From page 35 An interview with SRNA #2 on 02/07/12, at 11:20 AM, revealed the SRNA had been employed by the facility for "about two years, on and off." SRNA #2 stated she saw the sign but since she wasn't touching the resident she did not think she needed to wear gloves or a gown. When asked about adjusting the resident's oxygen tubing, SRNA #2 stated, "Oh, I did touch her, I forgot, I should have worn gloves."	F 441		
F 456 SS=E	An interview with the facility's Infection Control (IC) Nurse on 02/08/12, at 5:40 PM, revealed the IC Nurse was responsible to post the signage and in-service staff regarding the appropriate precautions. The IC Nurse further stated there was a reference book at the desk for staff to utilize to ensure all staff was aware of the precautions to be utilized. According to the IC Nurse, the Contact Isolation sign was posted on the door and everyone should have been aware of the precautions needed. 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and policy review, it was determined the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Observation during the environmental tour on 02/09/12, at 1:10 PM, revealed the facility's fifty-pound clothes washer had a	F 456	F 456 A work order was completed on 2/9/12 by the Housekeeping Supervisor related to the non-working thermometer. The thermometer was replaced on 02/15/2012.	

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F 456	<p>Continued From page 36</p> <p>non-working thermometer and as a result staff was unable to determine if the water temperature was within an acceptable range to ensure resident items were properly sanitized.</p> <p>The findings include:</p> <p>A review of the facility's policy related to maintenance of the facility (revised December 1998) revealed a safe and properly maintained facility would be provided and every effort would be made to provide repairs on a timely basis.</p> <p>Observation of the laundry room on 02/09/12, at 1:10 PM, revealed a 50-pound washer with a non-working thermometer.</p> <p>An interview conducted on 02/09/12, at 1:15 PM, with the Housekeeping Supervisor (HS) revealed the washing machine had not had a working thermometer for three months. The HS stated she had been told by the company that provided laundry chemicals to the facility that she could do "pH testing" until the thermometer could be repaired. The HS stated although she had not completed a maintenance work request to inform the Maintenance Department that the thermometer on the clothes washer was not working, she had verbally reported the problem to the Maintenance Supervisor (MS) approximately three months prior to the day of the observation.</p> <p>An interview conducted on 02/09/12, at 1:15 PM, with the MS revealed the facility used a "work order" system to report items in need of repair. According to the MS, after staff completes a work order, the requests were placed in a box at the nurses' station and a copy of the work order was</p>	F 456	<p><u>F456 Con't</u></p> <p>An audit was conducted on 03/01/2012 by QI Plant Committee to identify that all essential mechanical, electrical, and patient care equipment was in safe operating condition. A work order was completed for any repairs needed & equipment was removed from service no other equipment was identified.</p> <p>Facility Staff were re-educated on 03/01/2012 by Administrator regarding the work order completion process to inform the maintenance department and the Administrator of any equipment not working correctly. Newly hired employees will receive this information during the orientation process.</p> <p>When the work order is completed the white copy will go in the Maintenance box & the yellow carbon copy will be placed in the Administrator's box. When work orders are completed by Maintenance department they will initial the white copy & place it in the Administrator's box. A weekly QI</p>		

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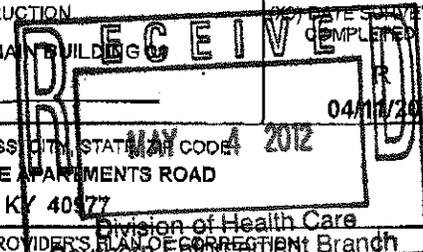
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F 456	<p>Continued From page 37</p> <p>also placed in the Administrative office for the Administrator to review. However, the MS stated a work order had not been written for the washer. According to the MS, he had been notified by the HS of the non-working thermometer on the washer. The MS stated he had reported the issue to the Administrator and the facility had been trying to decide whether to purchase a new machine or to repair the existing one. The MS also stated the thermometer on the clothes washer had not been in working order for approximately three months.</p> <p>An interview conducted with the Administrator on 02/09/12, at 1:25 PM, revealed the Administrator had not been aware that the thermometer on the 50-pound washer had broken. The Administrator stated she was responsible for checking maintenance work requests; however, she had not been aware of this issue.</p>	F 456	<p>F456 Con't</p> <p>audit will be completed by the Administrator to match up the white & yellow copies of the work orders to ensure that all have been addressed as indicated. A monthly safety Round will be conducted by QI plant committee to include a check of essential mechanical, electrical, & resident care equipment for safe operating condition. Any issues will be corrected immediately with the Administrator being notified of malfunction and corrective action in place. The results of the weekly audits and the monthly Safety Rounds will be reviewed in the monthly Executive QI Committee, consisting of the Medical Director, Administrator, DON, ADON, QI Nurse, Treatment Nurse, SDC, & MDS Nurses, for trends & the accompanying action with any further retraining or other such interventions implemented as necessary.</p> <p>March 25, 2012</p>	3/25/12	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE AND ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40177	
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{K 000}	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Diesel generator A life safety code follow up survey was initiated and concluded on 04/11/12. The findings that follow demonstrate continued noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. An additional follow-up survey will be initiated after the receipt of an acceptable plan of correction. Repeat deficiencies were cited with the highest deficiency identified at "F" level.	{K 000}	Mountain View acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Mountain View's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
{K 061}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 061}		



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

TITLE: Kelly M. Gaudin Administrator

(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.

05-04-12

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{K 061} SS=F	Continued From page 1 Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the building sprinkler system was maintained as required by NFPA standards. The facility was cited for the same deficient practice on 10/14/08, 01/20/10, and 02/08/12. This repeated deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 100 on the day of the survey. The findings include: During the Life Safety Code follow-up survey on 04/11/12, at 10:30 AM, an interview with the Administrator revealed the valve to the facility's sprinkler system had not been electronically supervised as of 04/09/12, as alleged in the plan of correction. This device ensures water to the facility's sprinkler system is not turned off inadvertently or otherwise. A project scope dated 03/27/12, was provided of the work to be completed by the sprinkler contractor, however, the Administrator stated the contractor told her the work would be completed when time became available. No specific date had been given. Reference: NFPA 101 (2000 Edition).	{K 061}	ID Prefix Tag K061 The outside pit that houses the valve to the facilities sprinkler system is now electronically supervised. The device was installed on April 24, 2012. There are no other outside pits controlling water flow to the facility sprinkler system. All staff was in serviced by the administrator on the location of the alarm signal when it alarms. On April 24, 2012. Testing will be done quarterly for the first year to ensure it functions properly. May 5, 2012	05-05-12

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

PRINTED: 04/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 04/11/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(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 061}	Continued From page 2 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. Reference: NFPA 72 (1999 Edition). 3-8.3.3.3.2* If a valve is installed in the connection between an alarm-initiating device intended to signal activation of a fire suppression system and the fire suppression system, the valve shall be supervised in accordance with the requirements of Chapter 2. A-3-8.3.3.3.2 Sealing or locking such a valve in the open position, or removing the handle from the valve, does not meet the intent of the supervision requirement.	{K 061}		
{K 062} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	{K 062}		

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{K 062}	<p>Continued From page 3</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure the sprinkler system was maintained as required by NFPA standards. The facility was cited for the same deficient practice on 10/14/08, 12/07/10, and 02/08/12. This repeated deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 100 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code follow up survey on 04/11/12, at 9:25 AM, with the Director of Maintenance (DOM), paint was observed on two sprinkler heads in the employee breakroom. An interview with the DOM on 04/11/12, at 9:25 AM, revealed these heads were due to be replaced by the sprinkler contractor in May 2012. The facility's plan of correction revealed the sprinkler heads should have been compliant by 03/25/12. Foreign matter on sprinkler heads decreases their ability to react as intended in a fire situation.</p> <p>Observation during the survey revealed the accelerator on the sprinkler riser was in the OFF position. An accelerator ensures the sprinkler system operates in a timely manner. An interview with the DOM on 04/11/12, at 10:15 AM, revealed the sprinkler company came on 03/12/12, to</p>	{K 062}	<p><u>ID Prefix Tag K062</u></p> <p>Sprinkler Heads located in the employee break were replaced on May 4, 2012. Simplex replaced the accelerator on April 18, 2012.</p> <p>Maintenance staff made rounds of facility and reviewed all sprinklers heads for dust or paint. Any sprinklers heads found to have paint or dust were cleaned and or replaced.</p> <p>Maintenance staff was in serviced by Administrator on continuously maintaining sprinklers keeping them free from corrosion and foreign materials.</p> <p>The Physical Plant QI Team will make monthly rounds to assess for any needed repairs for</p>	

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{K 062}	Continued From page 4 repair the accelerator, however, the accelerator could not be repaired and another one would have to be ordered. The facility's plan of correction revealed the accelerator should have been compliant by 03/25/12. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	{K.062}	<i>CONT</i> the next 12 months to ensure deficient practice does not recur. May 5, 2012	
{K 147} SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical wiring and standards met NFPA requirements. This repeated deficient practice affected one of five smoke compartments, staff, and approximately ten residents. The facility has the capacity for 115 beds with a census of 100 on the day of the survey. The findings include: During the Life Safety Code follow-up survey on	{K 147}	ID Prefix Tag K147 Power strip was removed from room 151. On April 11, 2012. Additional Electrical outlets were installed in the room on April 12, 2012, by Pace Heating and Air. Maintenance staff inspected the facility for any other extension cords/flexible cords/cables used as a substitute for permanent wiring on April 11, 2012. None identified.	05/05/12

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{K 147}	<p>Continued From page 5</p> <p>04/11/12, at 9:20 AM, with the Director of Maintenance (DOM) a power strip was observed to be in use with an electric bed, inflatable mattress, and a refrigerator in resident room 151. Power strips cannot be used with medical equipment or high draw appliances to help reduce against fire and electrical shock. This was the same resident bed that was cited on 02/08/12. A power strip with a long cord was being used to power this resident's TV. It is unacceptable to use flexible cords in this manner to an area that needs a permanent power source. An interview with the DOM on 04/11/12, at 9:20 AM, revealed the power strip was removed after the previous survey, however, he was not aware that someone put the power strip back. The DOM stated he was not aware that you could not use a power strip with a long cord as a permanent solution to an area that needs a permanent receptacle.</p> <p>The facility's plan of correction indicated this deficiency would be corrected by 03/25/12.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 	{K 147} CONT	<p>The Maintenance Department was in serviced by the Administrator on April 11, 2012 on Life Safety Code Standards specifically K. 147.</p> <p>The physical Plant QI team will make monthly rounds to ensure there are no flexible cords/cables being used as a substitute for permanent wiring.</p> <p>May 5, 2012.</p>	05-05-12

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{K 147}	Continued From page 6 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code 517-18. General Care Areas (b) Patient Bed Location Receptacles. Each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single or duplex types or a combination of both. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. Each receptacle shall be grounded by means of an insulated copper conductor sized in accordance with Table 250-122. FPN: It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	{K 147}		