

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2012
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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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F 000 INITIAL COMMENTS

F 282 SS=G 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

A Recertification Survey and Abbreviated Survey investigating KY#00019159 was initiated on 10/09/12 and concluded on 10/12/12. Deficient practice was cited with the highest level scope and severity of a "G". KY#00019159 was substantiated with no deficiencies cited.

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written plan of care for (2) of twenty-three (23) sampled residents (Resident #11 and Resident #23).

Review of Resident #11's Comprehensive Plan of Care revealed the resident was at risk of impaired skin integrity and approaches included the Certified Nursing Assistants (CNAs) assessing the skin with AM (morning) care and reporting any changes to the nurse. Further review revealed the nurses would to provide weekly skin audits and document and notify the physician of any changes, and apply Zinc Oxide Ointment to the bilateral buttocks as ordered.

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It is the policy of Carter Nursing and Rehabilitation Center to provide or arrange services by qualified persons in accordance with each resident's written plan of care.

The physician was notified on 10/15/12 by the DON and an order was received to allow SRNA's to apply the Zinc Oxide treatment to the resident after incontinent episodes. This was noted to be in addition to the application by the treatment/charge nurse three times per day. SRNA #9 did note a whitened area to the buttocks/coccyx on 10/7/12, however, that was not changed from previous assessments as that was the scar tissue that was present from his history of Stage III and IV pressure ulcers. After reading the Statement of Deficiencies, SRNA #9 states that the 2567 is inaccurate regarding her statement to the surveyor. She stated that the part of the wound that had changed was "the area at the top of the coccyx was more red" than it had been when she last visualized it.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wanda Meade (by hour) Director of Administration</i>	TITLE	(X6) DATE 11/5/12
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS A Recertification Survey and Abbreviated Survey investigating KY#00019159 was initiated on 10/09/12 and concluded on 10/12/12. Deficient practice was cited with the highest level scope and severity of a "G". KY#00019159 was substantiated with no deficiencies cited.	F 000			
F 282 SS-G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written plan of care for (2) of twenty-three (23) sampled residents (Resident #11 and Resident #23). Review of Resident #11's Comprehensive Plan of Care revealed the resident was at risk of impaired skin integrity and approaches included the Certified Nursing Assistants (CNAs) assessing the skin with AM (morning) care and reporting any changes to the nurse. Further review revealed the nurses would to provide weekly skin audits and document and notify the physician of any changes, and apply Zinc Oxide Ointment to the bilateral buttocks as ordered.	F 282	It is the policy of Carter Nursing and Rehabilitation Center to provide or arrange services by qualified persons in accordance with each resident's written plan of care. The physician was notified on 10/15/12 by the DCN and an order was received to allow SRNA's to apply the Zinc Oxide treatment to the resident after incontinent episodes. This was noted to be in addition to the application by the treatment/charge nurse three times per day. SRNA #9 did note a whitened area to the buttocks/coccyx on 10/7/12, however, that was not changed from previous assessments as that was the scar tissue that was present from his history of Stage III and IV pressure ulcers. After reading the Statement of Deficiencies, SRNA #9 states that the 2567 is inaccurate regarding her statement to the surveyor. She stated that the part of the wound that had changed was "the area at the top of the coccyx was more red" than it had been when she last visualized it.		
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Review of the last Skin Check Report of Non-Decub Skin Issues, dated 10/05/12, revealed Resident #11 had an area which was described as excoriation on the buttocks. However, on 10/11/12 during a skin assessment with the surveyor, the area was observed to have an unidentified area of black eschar 2.3 centimeters (cm) in length x 1.6 cm in width and was described by the nurse as unstageable with an area of white maceration surrounding the eschar and scant serous drainage just below the coccyx/on the right buttocks. There was no documented evidence the Plan of Care had been followed related to the staff documenting and notifying the physician of any changes related to the wound on the resident's coccyx/right buttock as evidenced by the facility failing to recognize the change in the wound when the wound progressed from an excoriation to an unstageable wound. However, although the Plan of Care stated the Zinc Oxide was to be applied to the resident's buttocks by the nurses which would allow for the nurses to assess the area each shift, interviews revealed the nurses had the CNAs apply the medication.

Review of Resident #23's Comprehensive Plan of Care revealed the resident had the potential for injury related to being a smoker. The approaches included keeping lighter and cigarettes in locked smokers cabinet or nurses station and resident to smoke only in designated smoking areas with staff supervision at all times. However, interviews with staff revealed they were unaware the resident was a supervised smoker, and were aware the resident went outside to smoke unescorted and was allowed to keep cigarettes in

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She stated that this is normal for this resident and that the redness would decrease after the resident changes positions, gets up in the wheelchair, or goes back to bed, depending on the previous position of the resident. She did notify the nurse that it was more red and the nurse told her to continue to apply the zinc oxide to the area. She stated that the scarring (white area) had not changed. The facility has a treatment nurse on day and evening shift. The treatment nurses apply the ointment to Resident #11 on day and evening shift. The treatment nurse working day shift on 10/7/12, who was not interviewed by the surveyor, assessed the wound on the morning of 10/7/12 and did not note any changes from previous assessments. She stated that the area was reddened, as usual, and the scarring portion of the skin was white, as usual.

The treatment nurse for evening shift on 10/7/12, who was not interviewed by the surveyor, stated that she applied the zinc oxide on the evening shift of 10/7/12 and did not note any changes from the previous assessments.

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his/her nightstand. The facility failed to follow the plan of care, on 10/11/12, when staff entered Resident #23's room, smelled smoke and noted a cigarette in a cup of water at the resident's bedside. Interviews with Resident #23 revealed she/he had been smoking in the room.

The findings include:

Review of the facility "Comprehensive Plan of Care Policy", revised 08/01/12, revealed it was the responsibility of each Interdisciplinary Team Member involved in the resident's care to provide input into the development, implementation, maintenance and evaluation of the resident's Plan of Care. All staff personnel who provide care should be knowledgeable and have access to the resident's Plan of Care.

1. Review of Resident #11's clinical record revealed he/she was re-admitted to the facility from the hospital, on 09/04/12, with diagnoses which included Renal/Uretal Disease, Diabetes Mellitus, Chronic Kidney Disease, and Bilateral Forefoot Amputation. The Departmental Notes, dated 09/04/12 at 11:13 PM, revealed the resident was re-admitted to the facility with a diagnoses of Renal Insufficiency. Further review of the Note, revealed the coccyx had several small shear areas which were red in color. The Re-admission Physician's Orders, dated 09/04/12, revealed orders for Zinc Oxide to be applied to the bilateral buttocks each shift. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/17/12, revealed the facility assessed Resident #11 as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact.

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The care plan for Resident #11 was updated by the IDCPT on 10/16/12 to reflect that the SRNA's could also apply the zinc oxide. On 10/11/12, the physician was notified of the change in the condition of the area as noted by the charge nurse and surveyor. The physician was notified and new orders were received and noted by the charge nurse. This was recorded on the plan of care by the MDSC on 10/12/12. The area healed on 10/22/12 and the treatment to the buttocks was discontinued. The plan of care was updated by the MDSC on 10/22/12 to reflect this change. The resident currently continues to have excoriation on his buttocks and coccyx area with zinc oxide paste being applied by the nurses and zinc oxide ointment being applied by the SRNA's after incontinent episodes. The current plan of care accurately reflects this most recent physician order.

The plan of care for resident #23 was reviewed by the MDSC on 10/12/12. It was noted that the POC was accurate and no changes were made to the plan of care at that time.

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F 282	<p>Continued From page 3</p> <p>Continued review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, transfers, and toilet use, as ambulation not occurring, and as having functional limitation in range of motion of the lower extremities. Further review revealed the facility assessed the resident as being at risk for pressure ulcers and as having no pressure ulcers.</p> <p>Review of a "Body Audit", dated 10/05/12, revealed a diagram of a body with a line drawn to the coccyx/buttocks area which stated "red". Review of the Skin Check Report of Non-Decub Skin Issues, dated 10/05/12, revealed the resident's buttocks had excoriation, and the treatment was Zinc Oxide.</p> <p>Review of the Comprehensive Plan of Care, with a problem onset date of 02/09/09, revealed Resident #11 was at risk of impaired skin integrity related to decreased mobility, a history of skin breakdown, and diagnoses of Peripheral Vascular Disease and Diabetes Mellitus, and incontinence of bowel. The Plan of Care was revised 9/24/12 to indicate the resident had an unstageable area to the left heel. The goal, with a target date of 12/21/12, stated the resident would be free of any further skin breakdown. Further review revealed the interventions were specific as to which staff were responsible; Certified Nursing Assistants (CNAs) were to assess the skin with am care, and report any changes to the nurse. The licensed nurses were to provide weekly skin audits and document, and notify physician of any changes, and were to apply Zinc Oxide Ointment to the bilateral buttocks as ordered.</p>	F 282	<p>The IDCPT, along with the DON, ADON and RN Supervisors, will complete walking care plan rounds on all residents no later than 11/14/12 to ensure that all interventions recorded on the current plan of care have been implemented as written.</p> <p>The Staff Development Coordinator will provide additional education to all nursing staff no later than 11/14/12 regarding the importance of implementing individual interventions as recorded on each resident's plan of care.</p> <p>The DON, ADON or the RN Supervisors will review a minimum of five care plans per week for four weeks to ensure that all interventions are implemented as recorded on the current plan of care. Any areas of concern that are identified will be addressed via staff education or an update to the plan of care, whichever is more appropriate. After four weeks, the DON or ADON will review at least four care plans per month for three months to ensure that interventions are appropriate and implemented.</p>	

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Review of the Medication Administration Record (MAR), dated 10/12, revealed Zinc Oxide 20% Ointment was to be applied to the bilateral buttocks every shift. The MAR designated the medication to be applied each day at 5:30 AM, 1:30 PM, and 9:30 PM and was signed off each shift as applied by the nurses.

Interview, on 10/12/12 at 10:15 AM, with CNA #9 revealed she was assigned to Resident #11 on 10/07/12 and she remembered the area to the resident's buttocks/coccyx was white on that date. She stated the nurses were aware and told her to put Zinc Oxide on the area. Continued interview revealed the nurses did not routinely apply the Zinc Oxide and the CNAs applied it after the nurse obtained it from the treatment cart. There was no documented evidence the wound was assessed by a licensed nurse after the wound was noted to change from an excoriation on 10/05/12 to the appearance of white tissue at the wound on 10/07/12.

Interview, on 10/12/12 at 9:15 AM, with Resident #11 revealed he/she received a shower on 10/09/12 and received a bed bath daily all over his/her body and lotion was also applied to his/her body with the bed bath. Resident #11 further stated he/she was unaware he had an area of skin breakdown to his/her coccyx/buttocks. Continued interview revealed the nurses did not come in each shift to apply the Zinc Oxide to the area; however, the aides did apply creams and lotions to the area.

Interview, on 10/12/12 at 10:45 AM, with CNA #10 revealed she had assisted Resident #11 with a shower on 10/09/12 and the resident's

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The results of these audits will be discussed weekly in the Focus Committee Meeting (a sub-committee of the Continuous Quality Improvement Committee) for four weeks. The results will also be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.

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F 282	<p>Continued From page 5</p> <p>coccyx/buttocks was "red" which was usual for this resident.</p> <p>Interview, on 10/12/12 at 9:30 AM with CNA #3, revealed she had assisted CNA #9 in transferring Resident #11 to the bathroom on 10/11/12 early on the day shift about 6:30 AM and she noted an area to the top of the buttocks which looked different because it was white in color and was usually red, and she reported it to the night nurse Licensed Practical Nurse (LPN) #3. She further stated LPN #3 said she would report it to the next nurse because she (LPN #3) was about to leave. CNA #3 stated she did not ask LPN #4, who was the day shift nurse to look at the area and was unsure if LPN #4 had assessed it. There was no documented evidence a licensed nurse had assessed this resident after the change in the wound was reported by CNA #3.</p> <p>Interview, on 10/12/12 at 9:00 AM, with LPN #4 revealed she was not notified on 10/10/12 or 10/11/12 of a change in Resident #11's skin.</p> <p>Observation, on 10/11/12 at 3:00 PM, of a skin assessment performed by the Nurse Manager of the South Unit, revealed an area below the coccyx/on the right buttock which the nurse described as black eschar, 2.3 cm in length x 1.6 cm in width, unstageable, with an area of white maceration surrounding the eschar and scant serous drainage. Interview at the time of the skin assessment with the Nurse Manager revealed she was unaware of the unstageable wound.</p> <p>Interview, on 10/12/12 at 3:00 PM with LPN #3, who was assigned to the resident on 10/10/12 from 10:00 PM until 6:00 AM on 10/11/12,</p>	F 282	

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revealed the CNAs applied the Zinc Oxide to Resident #11's coccyx/buttocks area which was obtained from central supply and came in packets, or she could obtained the medication from the treatment cart to give to the CNAs to apply. She stated she had not recently seen or assessed the area; however, no one had mentioned the area had changed.

Continued interview, on 10/12/12 at 10:15 AM, with CNA #9 revealed the nurses did not routinely apply the Zinc Oxide and the CNAs applied it after the nurse obtained it from the treatment cart. She stated she was not assigned to the resident again until 10/11/12 and when she performed the bed bath the morning of 10/11/12 she noticed a place on the buttocks/coccyx area which was white with redness around it. She further stated, she did not tell the nurse because it did not look different from 10/07/12, and she applied Zinc Oxide to the area which she obtained from the storage closet. Continued interview revealed the CNAs were to tell the nurses if they find a new area or a change in skin; however, she had concerns because sometimes the nurses would not follow up to check the skin when notified of changes.

Interview, on 10/12/12 at 12:00 PM, with LPN #2 revealed she had done treatments on the South Unit on 10/11/12 on day shift and did treatments all over the buildings on the days she worked. She stated she remembered applying Zinc Oxide to the resident's buttocks area that day. She stated she did treatments for Resident #11 all week and described the area to the coccyx/buttock as black areas and red areas and stated the wound looked the same all week. She

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further stated she was unsure when the eschar first occurred and was unaware if she had notified nursing or the physician. Further interview revealed she knew she was to notify the physician if she saw a change; however, she thought the Zinc Oxide was the treatment ordered for the eschar. She stated the Zinc Oxide that she applied was from pharmacy and was kept in the treatment cart. She further stated, she did not allow the CNAs to apply it.

Further interview, with the Nurse Manager of the South Hall, on 10/12/12 at 3:00 PM, revealed the CNAs and nurses were to notify the charge nurse or herself if a wound changed or if there was a new area of skin breakdown. After reviewing Resident #11's chart, she stated the "Body Audit" was done 10/05/12 and the wound must have worsened sometime between 10/05/12 and 10/11/12 at the time of the skin assessment with the surveyor. Further interview revealed the physician should have been notified as soon as the change in the wound occurred because Zinc Oxide would not be effective for eschar.

Interview, on 10/12/12 at 5:45 PM, with the DON revealed there was a failure by staff to report a change in Resident #11's wound as the area changed from a non-pressure area to a pressure area. She stated, there was a Physician's Order for Zinc Oxide and the intervention was on the MAR; therefore the nurses should have been assessing the site to monitor for changes in the wound, and applying the medication as ordered. Further interview revealed when a nurse or a CNA found a change in a wound or a new area of skin breakdown the nurse assigned was to assess the skin, notify the Unit Manager, Charge

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Nurse or herself as well as the physician was to be notified, as per the Plan of Care. The DON stated, there was a weekly Focus Meeting which she attended and skin problems were discussed. She stated if a new or worsened area of skin breakdown was noted, the nurses were to document this on the Twenty-Four (24) Hour Report in order for it to be discussed in the morning meeting in which all department heads attended; however, there was no notification on the 24 Hour Report related to Resident #11's change in the wound.

2. Review of Resident #23 medical record revealed she/he was admitted to the facility, on 08/10/12, with diagnoses which included Anxiety, Depression, Muscle Weakness, Chronic Obstructive Pulmonary Disorder (COPD), and Tobacco Use Disorder. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/02/12, revealed the facility assessed the resident as having a Brief interview for Mental Status (BIMS) score of twelve (12) which indicated moderate impairment in cognitive status. Further review revealed the facility assessed the resident as requiring extensive assistance with transfers and bed mobility, and locomotion, and as not ambulating.

Review of the Comprehensive Plan of Care, dated 09/21/12 and revised on 10/02/12, revealed Resident #23 had the potential for injury related to being a smoker with a goal that the resident would be free daily of injury related to smoking and would have no unidentified complications from smoking. The approaches included keeping lighter and cigarettes in locked smokers cabinet or nurses station, resident to smoke only in

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F 282	<p>Continued From page 9</p> <p>designated smoking areas with staff supervision at all times, redirect when resident is inappropriate with smoking habits, assist to supervised smoking areas at designated times, and provide smoking materials at supervised smoke breaks only.</p> <p>Review of the Safe Smoking Evaluation, dated 09/21/12, completed by Registered Nurse (RN) #7/MDS Nurse revealed the resident had short term memory loss. Review of the Summary of Evaluation Section, revealed the resident had to be supervised by staff, volunteer, or family member at all times while smoking. Also, the Evaluation stated, the resident must request smoking materials from staff, the resident/ representative/family have been informed of smoking evaluation results, the resident/representative/family have been informed of smoking policies/procedures, and the plan of care had been updated.</p> <p>Observation, on 10/12/12 at 8:30 AM, revealed Resident #23 approached the surveyor and the South Unit Manager in the hall and stated he/she did a "boo boo" last night. When the Unit Manager asked the resident what she/he had done, the resident stated she/he had smoked in her/his room.</p> <p>Interview, on 10/12/12 at 10:00 AM, with the Unit Manager of the South Unit revealed she was not informed of the smoking incident by staff. She further stated there was no documentation in the medical record and no Incident Report was completed related to the smoking incident. Further interview, revealed she did not know how Resident #23 could have obtained cigarettes</p>	F 282	

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unless her/his family brought them in as she/he was a supervised smoker.

Interview, on 10/12/12 at 11:15 AM and 1:45 PM, with Resident #23, revealed she/he was unsure of the exact time that she/he smoked in his/her room last night and further stated she/he was allowed by staff to carry cigarettes with him/her until today. Continued interview revealed Resident #23 had been recently admitted and he/she became confused and thought he/she was at home when he/she smoked in the room. Resident #23 stated his/her son brought cigarettes in and gave some to the nurses to lock up and let her/him keep some with him/her.

Further interview, on 10/12/12 at 2:15 PM, with the Unit Manager revealed she had found a note which was placed under her office door related to the incident and was unsure who the note was from. The Unit Manager stated she filled out the Incident Report after finding the note; however, the nurse who witnessed the incident should have completed an Incident Report related to the smoking incident.

Interview, on 10/12/12 at 2:30 PM, with CNA #7 revealed she worked the South Unit on 10/11/12 from 2:00 PM until 10:00 PM but was not assigned to Resident #23. He stated he had been assigned to the resident in the past and was unsure if she/he was a supervised smoker. He further stated, he was aware the resident carried cigarettes with him/her and kept them in the drawer in the nightstand drawer. Continued interview revealed there was a list for staff to refer to in regards to supervised smokers, however this resident was not on either the supervised or

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unsupervised smoking list and the list needed to be updated. He further stated he had asked the evening shift nurses in the past, if the resident could go outside to smoke unescorted and he was told that the resident could. He stated he had observed Resident #23 to go outside to smoke alone.

Interview, on 10/12/12 at 2:50 PM, with CNA #13 revealed she worked 10/11/12 on the South Unit from 10 PM until 6 AM and around 11:00 PM she and CNA #12 noted movement in Resident #23's room and went to check on the resident. She stated upon entering the room near the privacy curtain, they smelled smoke. She further stated the window was open and the resident had already put out the cigarette. Continued interview revealed she reported this to LPN #3 and LPN #5, who immediately came into the resident's room. CNA #13 stated, LPN #5 told the CNAs to get the cigarettes and put them in the locked drawer in the designates smoking area. According to CNA #13, Resident #23 kept apologizing for smoking in the room. CNA #13 indicated Resident #23 must be an unsupervised smoker because she had witnessed the resident to carry cigarettes with her/him. She further stated when the resident went to the hospital a few weeks ago, she (CNA #13) had put the resident's cigarettes and lighter in the top drawer of the night stand. Further interview revealed supervised smokers were not to have cigarettes and lighters and there was a list which indicated which residents were supervised smokers at the nurse's station. She was unsure if this resident was on the list.

Interview, on 10/12/12 at 3:15 PM, with Certified

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F 282	<p>Continued From page 12</p> <p>Nursing Assistant (CNA) #12 revealed she had worked the South Unit on 10/11/12 from 2:00 PM until 10:00 PM upon entering Resident #23's room after hearing movement she smelled smoke and observed a cigarette in a cup of water at the resident's bedside. She also observed the window was open in the resident's room. Further interview, revealed LPN #5 was notified and came in and confiscated the cigarettes and lighter while she and another CNA searched the room for more cigarettes and lighters, and some cigarettes were found in the resident's night stand.</p> <p>Interview, on 10/12/12 at 4:05 PM, with LPN #5 revealed she had worked the South Unit on 10/11/12 and worked from 2:00 PM until sometime after 10:00 PM. She stated she saw Resident #23 moving about in his/her room and asked CNA #12 and CNA #13 to go see about the resident as the resident may need to have assistance. LPN #5 stated CNA #13 told her Resident #23 was smoking in the room; however, when she (LPN #5) entered the room, the cigarette was already in the water. "It was obvious the resident had been smoking". She said the cigarettes and lighter were removed from the room by the CNAs. She further stated the resident had been a unsupervised smoker and had been going outside to smoke unescorted and always had cigarettes on his/her person. Further interview revealed there was a list at the nurse's station which indicated which residents required supervision and which residents could smoke independently. LPN #5 stated, as far as she knew, the residents who could smoke unsupervised could have lighters and she was aware some residents had lighters.</p>	F 282		

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Interview, on 10/12/12 at 4:35 PM, with RN #7/MDS Nurse revealed she had completed the Smoking Evaluation for Resident #23 and based on the resident's cognitive status she felt the resident should be supervised when smoking. Continued interview revealed after the Smoking Evaluation was completed, she was to inform MDS Nurse #2 who was responsible for updating the smoking list and the list was kept at the North Unit, South Unit and in the activities office

Observation, on 10/12/12 at 4:40 PM, of the Smokers List on the bulletin board at the nurses station on the South Hall where Resident #23 resided revealed Resident #23 was not on the list as a non supervised smoker or a supervised smoker.

Further interview with RN #7/MDS Nurse, on 10/12/12 at 4:45 PM, revealed Resident #23 was admitted on a Friday and she may not have told MDS Nurse #2 to update the list with Resident #23's name as a supervised smoker. She stated MDS Nurse #2 was on leave and unavailable for interview.

Interview, on 10/12/12 at 5:30 PM, with the Director of Nursing (DON) revealed Resident #23 was to be on the supervised smoker list which was kept at both nurse's stations and she was unaware this resident was not on the list at all. She indicated the resident would need to be on the supervised smoker list in order for staff to know whether the resident needed supervision with smoking as that was the reference used. She further stated the charge nurses or MDS nurses completed smoking assessments, and the

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MDS nurses were responsible for checking the list frequently to update them. Continued interview revealed as soon as the nurse completed the Smoking Evaluation, the nurse should have immediately update the Smokers List; however, she stated she was unsure of how quickly the resident's name went on the list after a Smoking Evaluation was completed. The DON further stated, there was a breakdown in communication if Resident #23's name was not on the supervised smoking list. She stated no smokers were allowed to have lighters and the staff gathered lighters from the residents frequently. When asked if there was any scheduled check/audit to see if supervised smokers had cigarettes or lighters, or if unsupervised smokers had lighters, she stated staff did not check the rooms on a routine or scheduled basis. Continued interview, revealed if staff recognized an issue with a supervised smoker having cigarettes or a unsupervised smoker having a lighter, the room would be checked. Further interview revealed the potential for harm was there if a resident was smoking in the room, and it would be important for staff to know which residents could not have cigarettes in their possession.

Interview, on 10/09/12 at 6:15 PM, with the Administrator and the Quality Assurance Director revealed the resident's name should go on the smoking list as soon as the smoking evaluation was completed which would be the day of admission for a new admit. Continued interview revealed there was a breakdown in communication related to the smoking policy and it would be important for staff to be knowledgeable as to who was a supervised

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smoker so that a staff member could be with a supervised smoker during smoking times per the plan of care.

F 282

F 314 483.25(c) TREATMENT/SVCS TO
SS=G PREVENT/HEAL PRESSURE SORES

F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

It is the policy of Carter Nursing and Rehabilitation Center to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure a residents having pressure sores received the necessary care and services to promote healing, prevent infection, and prevent new sores from developing for one (1) of twenty-three (23) sampled residents (Resident #11).

As noted in the 2567, there is confusion regarding appearance of the wound prior to the body audit on 10/11/12. However, during the Facility investigation regarding the worsening of the area, staff members were adamant that the area had not changed beyond anything normal for this resident prior to the area being identified on 10/11/12.

Resident #11 was assessed to have several small shear areas to the coccyx which were red in color upon re-admission to the facility on 09/04/12, and Zinc Oxide was ordered to the area. The area was described as excoriation on the Skin Check Report of Non-Decub Skin Issues, dated 10/05/12. However, observation on 10/11/12 during a skin assessment revealed the area was observed to have an unidentified area of black eschar 2.3 cm in length x 1.6 cm in width and was

All staff that cared for Resident #11 during the 72 hours prior to the skin assessment conducted on 10/11/12 with the charge nurse and surveyor was interviewed by administrative staff during an investigation initiated due to the change in skin condition noted on 10/11/12.

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described by the nurse as unstageable with an area of white maceration surrounding the eschar and scant serous drainage just below the coccyx/on the right buttocks. Although there was conflicting interviews with staff as to the appearance of Resident #11's coccyx/buttocks wound prior to the skin assessment with the surveyor on 10/11/12, there was no documented evidence the facility recognized the change in the wound when the wound became unstageable in order to obtain an appropriate treatment to promote healing.

The findings include:

Review of the facility's policy entitled "Pressure Sores Policy", dated 08/01/12, revealed if a resident developed a pressure sore, he or she would receive care and treatment to heal and prevent further development of pressure sores.

Review of the facility's policies entitled "Pressure Ulcer Guideline", revised 03/01/06, and "Introduction to Prevention and Management of Wounds", revised 03/01/06, revealed these policies were based on those developed by the Agency for Health Care Policy and Research and Quality. The "Pressure Ulcer Prevention Guideline" policy stated staff was to perform systematic skin inspections daily; review or modify as needed the individual's positioning, transfer, range of motion, sitting and turning schedule; update the individualized care plan as needed; and educate staff related to identification and role of those responsible for pressure sore prevention, etiology and risk factors for pressure sores, characteristics of normal skin, characteristics of tissue deformation, and staging

F 314

All staff members, including the treatment nurse and SRNA's, that cared for this resident on 10/11/12, state that the only changes to this resident's excoriation were the additional redness to areas on the buttocks and coccyx which was normal for this resident and would fade as pressure was shifted by repositioning. During interview with the DON on 10/17/12, LPN #2 states that she did not tell the surveyor that the resident had a blackened area to the coccyx. She stated that the surveyor asked her in several different ways if the area was black. She states that she told the surveyor that it was not black. She described the wound as reddened areas with white scar tissue noted at the top of the coccyx.

The physician was notified on 10/15/12 by the DON and an order was received to allow SRNA's to apply the Zinc Oxide treatment to the resident after incontinent episodes. This was noted to be in addition to the application by the treatment/charge nurse three times per day.

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of pressure ulcers. Review of the "Introduction to Prevention and Management of Wounds" policy revealed if a wound developed the goal of the program was to promote healing and revise and further monitor the facilities clinical wound management programs.

Review of Resident #11's medical record revealed he/she was re-admitted to the facility from the hospital on 09/04/12 with diagnoses which included Renal/Uretal Disease, Diabetes Mellitus, Chronic Kidney Disease, and Bilateral Forefoot Amputation. Review of the Departmental Notes, dated 09/04/12 at 11:13 PM, revealed the resident was re-admitted to the facility with a diagnoses of Renal Insufficiency. The Departmental Notes further documented the coccyx had several small shear areas which were red in color. The Re-admission Physician's Orders dated 09/04/12, revealed orders for Zinc Oxide-apply to bilateral buttocks each shift. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/17/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, transfers, and toilet use, as ambulation not occurring, and as having functional limitation in range of motion of the lower extremities. Continued review revealed the facility assessed the resident as being at risk for pressure ulcers and as having no pressure ulcers.

Review of the Skin Risk Assessment, dated 09/17/12, revealed the resident scored a fifteen

F 314
SRNA #9 did note a whitened area to the buttocks/coccyx on 10/7/12, however, that was not changed from previous assessments as that was the scar tissue that was present from his history of Stage III and IV pressure ulcers. After reading the Statement of Deficiencies, SRNA #9 states that the 2567 is inaccurate regarding her statement to the surveyor. She stated that the part of the wound that had changed was "the area at the top of the coccyx was more red" than it had been when she last visualized it. She stated that this is normal for this resident and that the redness would decrease after the resident changes positions, gets up in the wheelchair, or goes back to bed, depending on the previous position of the resident. She did notify the nurse that it was more red and the nurse told her to continue to apply the zinc oxide to the area.

She stated that the scarring (white area) had not changed. The facility has a treatment nurse on day and evening shift. The treatment nurses apply the ointment to Resident #11 on day and evening shift.

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(15) which indicated the resident was at risk for pressure related to; skin often moist, chair fast, made frequent though slight changes in body or extremity position independently, and required moderate to maximum assistance with moving.

Review of a weekly "Body Audit", dated 09/28/12, revealed a diagram of a body with a line drawn to the coccyx/buttocks area which stated "pink". Further review of a "Body Audit", dated 10/05/12, revealed a diagram of a body with a line drawn to the coccyx/buttocks area which stated "red".

Review of the Skin Check Report of Non-Decub Skin Issues, dated 10/05/12, revealed the resident's buttocks had excoriation, and the treatment was Zinc Oxide.

Review of the Comprehensive Plan of Care with a problem onset date of 02/09/09, revealed the resident was at risk of impaired skin integrity related to decreased mobility, a history of skin breakdown, and diagnoses of Peripheral Vascular Disease and Diabetes Mellitus and incontinence of bowel. Further review revealed the Plan of Care was revised 9/24/12 to indicate the resident had an unstageable area to the left heel. The goal with a target date of 12/21/12 revealed the resident would be free of any further skin breakdown. The interventions were specific as to which staff were responsible; Certified Nursing Assistants (CNAs) were to assess the skin with am care, and report any changes to the nurse. Nurses were to provide weekly skin audits and document, and notify physician of any changes, and nurses were to apply Zinc Oxide Ointment to the bilateral buttocks as ordered.

F 314

The treatment nurse working day shift on 10/7/12, who was not interviewed by the surveyor, assessed the wound on the morning of 10/7/12 and did not note any changes from previous assessments. She stated that the area was reddened, as usual, and the scarring portion of the skin was white, as usual. The treatment nurse for evening shift on 10/7/12, who was not interviewed by the surveyor, stated that she applied the zinc oxide on the evening shift of 10/7/12 and did not note any changes from the previous assessments. The care plan for Resident #11 was updated by the IDCPT on 10/16/12 to reflect that the SRNA's could also apply the zinc oxide. On 10/11/12, the physician was notified of the change in the condition of the area as noted by the charge nurse and surveyor. The physician was notified and new orders were received and noted by the charge nurse. This was recorded on the plan of care by the MDSC on 10/12/12. The area healed on 10/22/12 and the treatment to the buttocks was discontinued. The plan of care was updated by the MDSC on 10/22/12 to reflect this change.

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PRINTED: 10/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2012
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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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Review of the Medication Administration Record (MAR), dated 10/12, revealed an intervention for Zinc Oxide 20% Ointment, apply to bilateral buttock every shift. The MAR was designated for the medication to be applied each day at 5:30 AM, 1:30 PM, and 9:30 PM and was signed off each shift as applied by the nurses.

Interview, on 10/12/12 at 10:15 AM, with CNA #9 revealed she was assigned to Resident #11 on 10/07/12 and the area to the resident's buttocks/coccyx was white at that time. She said the nurses were aware and told her to put Zinc Oxide on the area. Further interview revealed the nurses did not routinely apply the Zinc Oxide and the CNAs applied it after the nurse obtained it from the treatment cart. There was no documented evidence the wound was assessed after the wound was noted to change from an excoriation on 10/05/12 to the appearance of white tissue at the wound on 10/07/12.

Interview, on 10/12/12 at 9:15 AM, with Resident #11 revealed he/she received a shower on 10/09/12 and received a bed bath daily all over his/her body and lotion was also applied to his/her body with the bed bath. Resident #11 further stated he/she was unaware he had an area of skin breakdown to his/her coccyx/buttocks because it was not sore. Further interview revealed the nurses did not come in each shift to apply the Zinc Oxide to the area; however, the aides did apply creams and lotions to the area.

Interview, on 10/12/12 at 10:45 AM, with CNA #10 revealed she had assisted Resident #11 with a complete shower on 10/09/12 and the resident's coccyx/buttocks was "red" which was usual for

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The resident currently continues to have excoriation on his buttocks and coccyx area with zinc oxide paste being applied by the nurses and zinc oxide ointment being applied by the SRNA's after incontinent episodes. The current plan of care accurately reflects this most recent physician order.

A head to toe skin assessment was completed on each resident by a licensed nurse during the week of 10/29/12-11/2/12. No changes to previous skin assessments were noted.

The Staff Development Coordinator will provide additional education to all nursing staff regarding facility skin protocols for the prevention and treatment of pressure ulcers and non-pressure ulcers no later than 11/14/12. This education will stress the importance of notification of the nurse regarding any skin changes in addition to the importance of nurse assessment and the nurse reporting changes to the physician and treatment nurse, if appropriate.

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F 314	<p>Continued From page 20 this resident.</p> <p>Interview on 10/12/12 at 9:30 AM with CNA #3, revealed she had helped CNA #9 assist Resident #11 to the bathroom on 10/11/12 early on the day shift about 6:30 AM and she noted an area to the top of the buttocks which looked different because it was white in color and was usually red. She stated she reported it to the night nurse Licensed Practical Nurse (LPN) #3. She stated LPN #3 said she would report it to the next nurse because she was about to leave. CNA #3 stated she did not ask LPN #4, the day shift nurse to look at it and was unsure if LPN #4 had assessed it. There was no documented evidence staff had assessed this resident after the change in the wound was reported by CNA #3.</p> <p>Observation of a skin assessment performed by the Nurse Manager of the South Unit on 10/11/12 at 3:00 PM, revealed an area below the coccyx/on the right buttock which the nurse described as black eschar, 2.3 cm in length x 1.6 cm in width, unstageable, with an area of white maceration surrounding the eschar and scant serous drainage. Interview at the time with the Nurse Manager who was conducting the skin assessment revealed she was unaware of the unstageable wound.</p> <p>Interview, on 10/12/12 at 3:00 PM with LPN #3, who was assigned to the resident on 10/10/12 from 10:00 PM until 6:00 AM on 10/11/12 revealed the CNAs applied the Zinc Oxide to Resident #11's coccyx/buttocks area which was obtained from central supply and came in packets, or she could obtained the tube from the treatment cart to give to the CNAs to apply. She</p>	F 314	<p>The facility will implement a communication sheet by 11/9/12. In addition to verbal notification, the communication sheet will be used by the SRNA's to alert the charge nurse regarding changes in skin conditions and other resident information via written format. The charge nurse will review these communication sheets at the end of each shift to ensure that any changes in resident skin or overall condition have been assessed and that documentation and notification have occurred if needed. The SDC will provide education to all nursing staff regarding this additional system of communication by 11/9/12.</p> <p>The DON, ADON, or RN Supervisor will do at least 10 random skin audits per week for four weeks to ensure that the current skin assessments are accurate and that facility treatment protocols are followed as outlined in the facility Wound Care Manual.</p> <p>These audits will be discussed weekly at the Focus Meeting (a sub-committee of the monthly CQI Committee Meeting) and forwarded to the CQI Committee Meeting for further monitoring and continued compliance.</p>	

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stated she had not recently seen or assessed the area, however, no one had mentioned the area had changed.

Interview, on 10/12/12 at 9:00 AM, with LPN #4 revealed she was not notified on 10/10/12 or 10/11/12 of a change in Resident #11's skin.

Further interview, on 10/12/12 at 10:15 AM, with CNA #9 revealed the nurses did not routinely apply the Zinc Oxide and the CNAs applied it after the nurse obtained it from the treatment cart. She stated she was not assigned to the resident again until 10/11/12 and when she performed the bed bath the morning of 10/11/12 she noticed a place on the buttock/coccyx area which was white with redness around it. She further stated, she did not tell the nurse because it did not look different from 10/07/12, and she applied Zinc Oxide to the area which she obtained from the storage closet. Continued interview revealed the CNAs were to tell the nurses if they found a new area or a change in skin; however, she had concerns because sometimes the nurses would not follow up to check the skin when notified of changes.

Interview, on 10/12/12 at 12:00 PM, with LPN #2 revealed she had done treatments on the South Unit on 10/11/12 on day shift and did treatments all over the buildings on the days she worked. She stated she remembered applying Zinc Oxide to the resident's buttocks area that day. She stated she did treatments for Resident #11 all week and described the area to the coccyx/buttock as black areas and red areas and stated the wound looked the same all week. She further stated she was unsure when the eschar

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first occurred and was unaware if she had notified nursing or the physician. Further interview revealed she knew she was to notify the physician if she saw a change; however, she thought the Zinc Oxide was the treatment ordered for the eschar. She stated the Zinc Oxide that she applied was from pharmacy and was kept in the treatment cart. She further stated, she did not allow the CNAs to apply it.

Review of the Prescriptions delivered from pharmacy for Resident #11 revealed there was only one prescription filled for Zinc Oxide Ointment on 09/05/12 and none filled after this date.

Further interview, on 10/12/12 at 3:00 PM, with the Unit Manager revealed the CNAs and nurses should notify the charge nurse or herself if there were wound changes or if there was a new area of skin breakdown. She reviewed the chart and stated the "Body Audit" was completed 10/05/12 and the wound must have worsened sometime between 10/05/12 and 10/11/12 at the time of the skin assessment that was requested by the surveyor. She further stated the physician should have been notified a soon as the change in the wound occurred because Zinc Oxide would not be effective for eschar.

Interview, on 10/12/12 at 5:45 PM, with the Director of Nursing (DON) revealed there was a failure by staff to report a change in the wound as the area changed from a non-pressure area to a pressure area. She further stated, there was a Physician's Order for Zinc Oxide and the intervention was on the MAR; therefore the nurses should have been assessing the site to

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F 314 Continued From page 23
monitor for changes in the wound, and applying the medication as ordered. Continued interview revealed when a nurse or a CNA found a change in a wound or a new area of skin breakdown the nurse assigned was to assess the skin, notify the Unit Manager, Charge Nurse or herself and the Physician was to be notified. She stated there was a weekly Focus Meeting which she attended and skin problems were discussed. She further stated if a new or worsened area of skin breakdown was noted, the nurses would document this on the Twenty-Four (24) Hour Report in order for it to be discussed in the morning meeting in which all department heads attended; however, there was no notification on the 24 Hour Report related to Resident #11's change in the wound.

Review of the Physician's Order, dated 10/11/12 at 5:15 PM, revealed orders to cleanse the unstageable area to the right lower coccyx with wound cleanser and apply Santyl and dry dressing every shift.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=E
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

F 314
F 323
It is the policy of Carter Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The name of resident #23 was added to the Supervised Smoking list by MDSC on 10/12/12.

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Based on observation, interview, record review and review of facility policies, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents.

The facility failed to ensure there was an effective system in place to communicate to staff which residents were supervised smokers. Interviews with staff revealed they were unaware Resident #23 was a supervised smoker and they allowed him/her to keep cigarettes in the resident's room. On 10/11/12, when staff entered Resident #23's room, they smelled smoke and noted a cigarette in a cup of water at the bedside. Interviews with Resident #23 revealed she/he had been smoking in the room. In addition, the facility failed to follow their Incident Reporting Policy after Resident #23 was found smoking in her/his room.

In addition, observations during the initial tour revealed the facility failed to ensure disposable razors, liquid disinfectant cleaner and a bathroom cleaner were secured/locked and not accessible to confused residents.

The findings include:

Review of the facility policy entitled "Smoking Policy", revised 12/01/10, revealed the purpose of the policy was to maximize the ability to provide a safe environment for all resident, visitors, and staff and to perform assessments which determined a resident's ability to smoke safely and determine what additional measures were

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The DON reviewed the list of supervised and unsupervised smokers on 10/12/12 to ensure that all smoking residents were listed on the sheet and that each resident had the appropriate supervised or unsupervised designation, based on the information obtained from the last Smoking Evaluation completed for each resident.

The razor was removed from Room #4 by the ADON on 10/10/12. She educated the resident in room #4 regarding the importance of keeping razors in his drawer at that time. The disinfectant and cleaning solution was removed from the shower room by the RN Supervisor on 10/9/12.

An environmental audit was completed by the DON and ADON on 10/17/12 to identify any environmental issues that could potentially cause injury/accident to any resident. Any outstanding issues were corrected when identified.

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needed to protect residents from possible self inflicted injury due to smoking habits. The procedure was noted as follows; upon admission, quarterly, and with any change in condition, it was to be determined by the nurse if the resident required supervision while smoking utilizing the "safe smoking evaluation", place determination from evaluation in the Nurse's Notes, when the determination had been made that a given resident was a supervised smoker, the nurse would send a memo to the social services office and the Director of Nursing (DON) office. Further review revealed no fire igniting material was to be in any resident's possession at any time and staff was to monitor for and obtain smoking materials for the benefit of the smokers at the nurse's station or other designated location. Smoking materials themselves in addition to igniting materials may be controlled for particular patients. Residents may only smoke in the designated smoking area. Supervised smokers could only smoke with a staff member present in the smoking area. The rooms of smokers should be inspected for smoking materials routinely and when oxygen is initiated. At no time was smoking permitted in the resident's room. Residents could not carry smoking materials unless approved by the Interdisciplinary Team.

Review of the Resident/Visitor Incident Reporting Policy, revised 01/21/11, revealed the Incident Report was used to record facts of an occurrence with the purpose of improving procedures to create a safer environment. An effective risk management program must have an effective incident reporting, investigation, and corrective action procedure. The facility would complete incident reports on occurrences defined as a

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The MDSC's and all licensed staff will receive additional education by the DON and/or Staff Development Coordinator by 11/14/12 related to the importance of ensuring that any resident who enters the facility as a smoker has a Safe Smoking Evaluation completed on admission and that the resident name is placed on the smoking list with an appropriate designation that indicates if a resident is to be supervised or unsupervised. Additionally, the DON, ADON, Social Services Director, RN Supervisor or LPN Charge Nurse will review each new admission within two hours to determine that any resident who smokes has a Safe Smoking Evaluation completed and that their name has been placed on the smoking list with the appropriate designation of supervised or unsupervised smoking.

All staff received additional education by the DON, ADON, Staff Development Coordinator, or the RN Supervisor regarding the smoking policy and the importance of ensuring that the policy is followed for all supervised and unsupervised smoking residents. Additionally, if they note that a resident is not on either list, they are to report immediately to their supervisor so that the Safe Smoking Evaluation can be reviewed and the resident name can be placed on the appropriate list.

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F 323 Continued From page 26 smoking infraction.

1) Resident #23 was admitted to the facility, on 08/10/12, with diagnoses which included Anxiety, Depression, Muscle Weakness, Chronic Obstructive Pulmonary Disorder (COPD) and Tobacco Use Disorder. Review of the Admission Minimum Data Set (MDS) dated 10/02/12, revealed the facility assessed the resident as having a Brief interview for Mental Status (BIMS) score of twelve (12) indicating the resident had moderate impairment in cognitive status. Further review revealed the facility assessed the resident as requiring extensive assistance with transfers and bed mobility, extensive assistance with locomotion, and as ambulation did not occur.

Review of the Comprehensive Plan of Care dated 09/21/12 and revised on 10/02/12, revealed the resident has the potential for injury related to being a smoker with a goal that the resident would be free daily of injury related to smoking and would have no unidentified complications from smoking. The interventions included keeping lighter and cigarettes in locked smokers cabinet or nurses station, resident to smoke only in designated smoking areas with staff supervision at all times, redirect when resident was inappropriate with smoking habits, assist to supervised smoking areas at designated times, and provide smoking materials at supervised smoke breaks only.

Review of the Safe Smoking Evaluation, dated 09/21/12, completed by Registered Nurse (RN) #7/MDS Nurse revealed Resident #23 had short term memory loss, was able to communicate reasons oxygen must always be turned off and

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The education will also stress the importance of reporting any violation of the smoking policy to a supervisor, including the act of residents possessing igniting materials or smoking materials, if prohibited by the policy.

All staff received additional education by the ADON or Staff Development Coordinator by 11/14/12 regarding the importance of providing each resident with a safe environment that remains as free of accidents and hazards as possible; and the importance of each resident receiving the appropriate supervision and assistive devices to prevent accidents. This education includes ensuring that all potentially harmful substances/items will be stored out of reach or behind a locked door in order to prevent confused residents from accidentally obtaining them.

All new admissions that are smokers will be discussed daily (M-F) in morning nursing report. The ADON, Social Services Director, or RN Supervisor will ensure that a Safe Smoking Evaluation has been completed and will visually ensure that the resident name is on the smoking list with the appropriate designation.

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removed from surroundings prior to lighting cigarettes, was able to communicate the risks associated with smoking, smoked safely only in designated areas, utilized ash trays safety and properly; was able to place ashes in ashtray and did not cause or allow sparks or lit tobacco to fall anywhere but into ashtray. However, review of the Summary of Evaluation Section revealed the resident must be supervised by staff, volunteer, or family member at all times while smoking. In addition, the Evaluation stated the resident must request smoking materials from staff, the resident/ representative/family have been informed of smoking evaluation results, the resident/representative/family have been informed of smoking policies/procedures and the plan of care had been updated.

Observation on 10/12/12 at 8:30 AM, revealed Resident #23 approached the surveyor and the South Unit Manager and stated he/she did a "boo boo" last night. When the Unit Manager asked the resident what he/she had done, the resident stated she/he had smoked in her/his room.

Interview, on 10/12/12 at 10:00 AM, with the Unit Manager of the South Unit revealed she was unaware of the smoking incident until Resident #23 told her what happened. She stated she was unaware of how Resident #23 could have obtained cigarettes unless her/his family brought them in as she/he was a supervised smoker. She stated there was no documentation in the medical record and no Incident Report was completed per facility policy.

Interview, on 10/12/12 at 11:15 AM and 1:45 PM, with Resident #23, revealed he/she was unsure

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On Saturday and Sunday, the RN Supervisor will review new admissions and ensure that a Safe Smoking Evaluation has been completed and that the name is on the appropriate list. The week-end RN Supervisor will complete this task on Saturday and Sunday. The Administrator, DON, ADON, RN Supervisor or Housekeeping Maintenance Supervisor will make daily compliance rounds (M-F) to ensure that the environment remains as free of hazards as possible. The RN Supervisor will make daily compliance rounds on the week-ends. Any identified issues will be reported to the appropriate personnel and corrected.

The results of the above listed reviews will be discussed weekly in Focus Meeting (a sub-committee of the CQI Meeting) for eight weeks to ensure compliance. The results will also be forwarded to the monthly CQI Meeting for further monitoring and continued compliance.

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edema, tissue damage, and chemical burns; ingestion to be harmful or fatal if swallowed; skin contact may cause chemical burns; eye contact is corrosive caused eyes to burn and may cause temporary to permanent vision loss and blindness. Furthermore, the MSDS stated the chemical was corrosive to all body tissues and harmful skin contact may not cause immediate pain.

Review of the Spitfire MSDS, undated, revealed the product contained two (2) hazardous ingredients including Monoethanolamine and 2-Butoxyethanol. The MSDS listed this chemical to be in the "Immediate" Hazard Category. Personal protection equipment needed to reduce the risk for exposure would be goggles for eye protection and chemical resistant gloves for hand protection. The MSDS further revealed for ingestion to immediately contact a physician or poison center.

Interview, on 10/09/12 at 7:40 PM, with Nursing Supervisor #1 revealed the cabinet should have been locked.

Interview, on 10/12/12 at 5:00 PM, with State Registered Nursing Assistant (SRNA) #5 revealed the cabinets in the resident shower rooms were to be locked. SRNA #5 further revealed the chemicals that were stored in the cabinets could be dangerous to the residents.

Interview, on 10/12/12 at 5:20 PM, with Nursing Supervisor (NS) #3 revealed the facility does not have a policy regarding storage of chemicals.

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL SS=D NEEDS F 328

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of the exact time that he/she smoked in his/her room last night and further stated she/he was able to carry cigarettes with him/her until today. Continued interview revealed he/she had been recently admitted, and she/he became confused and thought she/he was at home when he/she was smoking in the room. Resident #8 stated his/her son brought cigarettes in and gave some to the nurses to lock up and let him/her keep some in his/her room. When asked if he/she was aware of where he/she was supposed to smoke, he/she was able to point to the smoking room and also stated he/she could smoke outside.

Further interview, on 10/12/12 at 2:15 PM, with the Nurse Manager revealed she had spoken with social services related to the incident and a call was placed to the residents Power of Attorney with a message left by social services. She stated she had found a note which was placed under her office door related to the incident and was unsure who the note was from. Continued interview revealed she (Nurse Manager) filled out the Incident Report after finding the note; however, the nurse who witnessed the incident should have completed an Incident Report related to the smoking incident.

Interview on 10/12/12 at 2:30 PM with CNA #7, revealed she worked the South Unit on 10/11/12 from 2:00 PM until 10:00 PM. He stated she did not smell smoke on the hall, but heard a nurse found Resident #23 smoking in his/her room. He stated he has been assigned to the resident in the past and was unsure if he/she was a supervised smoker. However, he was aware the resident carried cigarettes with him/her and kept them in the drawer in the nightstand drawer. He

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further stated there was a list for staff to refer to in regards to supervised smokers, however this resident was not on the list. He stated the list needed to be updated because the resident was not on either the supervised or unsupervised smoking list. He further stated he had asked the evening shift nurses before if the resident could go outside to smoke unescorted and he was told that the resident could, and he had observed Resident #23 to go outside to smoke alone.

Interview, on 10/12/12 at 2:45 PM, with the Social Services Director revealed she reviewed the smoking policy with the smokers on admission and explained that no lighters or matches could be kept in the residents possession. She stated when cigarettes are brought in by the families for the supervised smokers they are given to the receptionist and then are locked up. However, she stated families sometimes brought in lighters and cigarettes without staff's knowledge. Continued interview revealed she and other staff members searched resident rooms for lighters and cigarettes routinely 2-3 times a month and staff had been educated to look for cigarettes and lighters as they assist with care and if lighters were found, they were to give them to the nurse. If cigarettes were found in the supervised smokers room, they were to give those to the nurses. However, she had no documented evidence the resident rooms were being checked.

Interview, on 10/12/12 at 2:50 PM, with CNA #13 revealed she worked 10/11/12 on the South Unit from 10 PM until 6 AM. She stated around 11:00 PM she and CNA #12 noted movement in Resident #23's room and they went to the room and smelled smoke. She stated the window was

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open and the resident had already put out the cigarette. She stated she reported this to LPN #3 and LPN #5, who immediately came into the resident's room. She stated LPN #5 told the CNAs to get the cigarettes and put them in the locked drawer in the designated smoking area. Further interview revealed Resident #23 kept apologizing for smoking in the room. CNA #13 stated Resident #23 must be a unsupervised smoker because she had witnessed the resident to carry cigarettes with him/her. She also stated when the resident went to the hospital a few weeks ago, she (CNA #13) had put the resident's cigarettes and lighter in the top drawer of the night stand. She stated supervised smokers were not to have cigarettes and lighters. She further stated there was a list which indicated which residents were supervised smokers at the nurse's station; however, she was unsure if this resident was on the list.

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Interview, on 10/12/12 at 3:15 PM, with Certified Nursing Assistant (CNA) #12 revealed she had worked the South Unit on 10/11/12 from 2:00 PM until 10:00 PM and she entered Resident #23's room after hearing movement and smelled smoke upon entering some time late in the evening. She stated she observed a cigarette in a cup of water at the resident's bedside. She also stated she noticed the window was open in the room. Continued interview, revealed LPN #5 was notified and came in took the cigarettes and lighter while she and another CNA searched the room for more cigarettes and lighters, and some cigarettes were found in the resident's night stand. She stated the nurse should have initiated an Incident Report and she was to sign; however, the nurse must not have completed it because

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she was not asked to sign. Further interview revealed she was aware the resident was a supervised smoker and was not aware of the resident ever smoking in the room or having cigarettes in the room until this incident.

Interview, on 10/12/12 at 4:05 PM, with LPN #5 revealed she had worked the South Unit on 10/11/12 and worked from 2:00 PM until after 10:00 PM. She stated she saw Resident #23 moving about in his/her room and asked CNA #12 and CNA #13 to go check on him/her. She stated CNA #13 told her Resident #23 was smoking in the room; however, when LPN #5 entered the room, the cigarette was already in the water. "It was obvious the resident had been smoking". She said she had the cigarettes and lighter removed from the room by the CNAs. She stated the resident had been a unsupervised smoker and had been going outside to smoke unescorted and always had cigarettes on his/her person. She stated there was a list at the nurse's station which indicated which residents required supervision and which residents could smoke independently. Continued interview revealed as far as she knew, the residents who could smoke unsupervised could have lighters and she was aware some resident had lighters. Further interview revealed she did not complete an Incident Report related to the smoking infraction because the incident occurred at the end of her shift, and she thought the oncoming nurse LPN #3 would document an Incident Report.

Multiple attempts were made to contact LPN #3; however, the nurse did not return the calls.

Interview, on 10/12/12 at 4:35 PM, with RN

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#7/MDS Nurse revealed she had completed the Smoking Evaluation for Resident #23 and based on the resident's cognitive status she felt the resident should be a supervised smoker. Further interview, revealed after the Smoking Evaluation was completed, she was to inform MDS Nurse #2 who was responsible for updating the smoking list and the list was kept at the North Unit, South Unit and in the Activities' office

Observation, on 10/12/12 at 4:40 PM, of the Smokers List on the bulletin board at the nurses station on the South Hall where Resident #23 resided, revealed Resident #23 was not listed as a supervised or non supervised smoker.

Further interview with RN #7/MDS Nurse, on 10/12/12 at 4:45 PM, revealed Resident #23 was admitted on a Friday and she may have forgotten to tell MDS Nurse #2 to update the list with Resident #23's name as a supervised smoker. Continued interview revealed MDS Nurse #2 was on leave and unavailable for interview.

Interview, on 10/12/12 at 5:30 PM, with the Director of Nursing revealed Resident #23 was to be on the supervised smoker list which was kept at both nurse's stations; however, she stated she was unaware this resident was not on the list at all. She stated, "if the resident was not on the list, how would staff know if the resident was a supervised smoker". She further stated the charge nurses or MDS nurses completed smoking assessments, and the MDS nurses were to check the list frequently to update them. Continued interview revealed as soon as the nurse completed the Smoking Evaluation, the nurse should go immediately and update the list;

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however, she stated she was unsure of how quickly the resident's name went on the list after an Evaluation was completed. Further interview revealed there was a breakdown in communication if Resident #23's name was not on the supervised smoking list. She stated no smokers were allowed to have lighters and the staff gathered lighters from the residents frequently. When asked if there was any scheduled check to see if supervised smokers had cigarettes or lighters, or if unsupervised smokers had lighters, she stated staff did not check the rooms on a routine or scheduled basis. She further stated if staff recognized an issue with a supervised smoker having cigarettes or a unsupervised smoker having a lighter, the room would be checked. She stated the potential for harm was there if a resident was smoking in the room, and it would be important for staff to know which residents could not have cigarettes in their possession. In addition, she stated the nurse should have filled out an Incident Report related to Resident #23 smoking in his/her room as per their policy, and this incident should have been documented on the Twenty-Four (24) Hour Report; however, there was no documented evidence of this information on the 24 Hour Report.

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Interview, on 10/09/12 at 6:15 PM, with the Administrator and the Quality Assurance Director revealed resident's name should go on the smoking list as soon as the smoking evaluation was completed which would be the day of admission for a new admission. Further interview revealed there was a breakdown in communication related to the smoking policy and it would be important for staff to be

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knowledgeable as to who was a supervised smoker so that a staff member could be with a supervised smoker during smoking times.

2) Review of the facility's policy entitled "Preventing Needlesticks and Sharps Injuries", dated 10/01/02, revealed the facility adhered to the requirements of Occupational Safety and Health Administration (OSHA) regarding usage of safer medical devices and preventing sharps and other needlestick injuries. OSHA 1910.1030 (d)(4)(iii)(A)(a) required contaminated sharps be discarded immediately or as soon as feasible in appropriate containers.

Observation during initial tour, on 10/09/12 at 7:25 PM, revealed a blue uncapped disposable razor on the sink in resident room six (6).

Observation, on 10/12/12 at 9:50 AM, revealed a blue uncapped disposable razor on the sink in resident room four (4).

Interview, on 10/12/12 at 9:50 AM, with Licensed Practical Nurse (LPN) #1 revealed the razor belonged to the resident of that room. LPN #1 stated that the resident is able to shave him/herself but should store the razors in a drawer. LPN#1 further stated that it could be hazardous if another resident obtained access to the razor.

Interview, on 10/12/12 at 10 AM, with Nursing Supervisor #3 revealed the normal procedure was to not allow a resident to keep razors in their room. Interview further revealed razors should be stored in the locked supply room and disposed of in the bio-hazard box after use.

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Interview, on 10/12/12 at 2:00 PM, with the Director of Nursing revealed the facility has no policy regarding residents keeping razors in their rooms but they would follow OSHA guidelines to use sharp containers to dispose of razor after use.

3) Review of the facility's policy entitled "Medication Storage in the Facility", undated, revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Further review of the policy revealed potentially harmful substances (household poisons, cleaning supplies and disinfectants) were clearly identified and stored in a locked area.

Observation during initial tour, on 10/09/12 at 8:25 PM, revealed an unlocked cabinet on the North Hall in the shower room contained two (2) one-gallon bottles of Invacare disinfectant. Observation further revealed an unlocked cabinet on the South Hall in the shower room contained one (1) bottle of Spitfire Power Cleaner.

Review of the Invacare Disinfectant Material Safety Data Sheet (MSDS), undated, revealed the chemical was listed in the corrosive material classification. Further review revealed five (5) hazardous ingredients including Dimethyl Benzyl Ammonium Chloride, Octyl Decyl Dimethyl Ammonium Chloride, Didecyl Dimethyl Ammonium Chloride, Ethanol: Ethyl Alcohol and Sodium Metasilicate. The MSDS for this chemical listed the Health Hazard Data to include:
Inhalation of the mists may cause pulmonary

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The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents received proper treatment and care of foot disorders by qualified persons including the treatment of nail disorders for one (1) of twenty-three (23) sampled residents (Resident #8). Resident #8 was observed to have long thick curled yellow toenails on 10/09/12 and 10/11/12. Record review and interviews with facility staff and Resident #8's family revealed the facility failed to ensure Resident #8 received care and treatment by a podiatrist.

The findings include:
Review of the facility policy titled "Podiatry-Foot Care", revised 08/01/12, revealed any resident with a foot disorder including nail disorder or preventative care that required treatment beyond the scope of the licensed nurse would be referred to the resident's physician or other qualified

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It is the policy of Carter Nursing and Rehabilitation Center to ensure that residents receive proper treatment and care for special services.

The podiatrist saw resident #8 on 10/19/12 and her toenails were clipped at that time.
All residents were assessed no later than 10/26/12 by the ADON or RN Supervisor to ensure that any resident needing podiatrist services were added to the podiatrist list for his next visit.

All nursing staff received additional education by the Staff Development Coordinator no later than 11/14/12 regarding the importance of maintaining a current list of residents in need of podiatry services so that the podiatrist can service them on his next visit. The podiatrist was educated on 10/19/12 by the DON regarding the importance of communicating to the facility if a resident refuses services for any reason.

The ADON or RN Supervisor will assess at least five residents per week for eight weeks to ensure that podiatry services are being provided as needed.

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person. Continued review of the policy revealed podiatry services provided by either a Podiatrist or other qualified person would be obtained and utilized.

Record review revealed the facility re-admitted Resident #8 on 10/13/09, with diagnoses which included Hypertension, Dementia, Depression, Chronic Pain, Urinary Retention, Osteoarthritis, and Acute/Chronic Renal Failure.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/11/12, revealed the facility assessed Resident #8 as having a Brief Interview for Mental Status (BIMs) score of seven (7), indicating cognitive impairment. Further review revealed the facility assessed Resident #8, as requiring extensive assistance with activities of daily living (ADLs) including grooming and hygiene, and as having functional limitations due to contractures and impairment of both lower extremities.

Observation, on 10/09/12 at 8:30 PM, during initial tour of the facility, revealed Resident #8 had long thick curled yellow toenails bilaterally.

Observation, on 10/11/12 at 9:45 AM, during Resident #8's skin assessment conducted by Registered Nurse (RN) #1 revealed Resident #8 continued to have long thick curled yellow toenails bilaterally. Interview with RN #1 at that time revealed Resident #8 was in need of nail/foot care by a Podiatrist. She stated the Podiatrist visited every other month, but she was not aware if Resident #8 had ever received nail/foot care. RN #1 did report that the current procedure for Podiatrist consultation included

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The results of these assessments will be discussed weekly in the Focus Committee Meeting (a sub-committee of the monthly CQI Committee meeting) and will also be forwarded to the monthly CQI Meeting for further monitoring and continued compliance.

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placing the resident's name on a Podiatrist list kept at the nurses station. She reported when the contracted Podiatrist visited the facility he utilized a list made by the nurses to make rounds on patients needing nail/foot care services. Additional interview revealed RN #1 was unaware of how foot care was documented and could not locate any evidence of nail/foot care in Resident #8's medical chart.

Review of the weekly skin assessments conducted by Licensed Practical Nurses (LPNs) entitled, "Body Audits" revealed thick long yellow toenails had been noted on eleven (11) different occasions dated from 03/01/12 to 09/20/12.

Review of Resident #8's medical chart including Flowsheets, Nurse's Notes, and Consults, from 03/01/12 through 09/20/12 revealed no evidence of nail/foot care being performed nor was there documented evidence of podiatry consultations. In addition, there was no documented evidence nail/foot care had ever been refused by Resident #8.

Interview with Resident #8's daughter, on 10/11/12 at 10:40 AM, revealed she had concerns the resident was not receiving foot/nail care. The daughter reported several months ago she told "more than one nurse" Resident #8 needed to see the podiatrist due to the condition of his/her toenails. The daughter reported she did not understand why Resident #8's toenails had not been addressed.

Interview with the Director of Nursing (DON), on 10/11/12 at 11:30 AM, revealed the Podiatrist visited the facility on the scheduled visit dates set

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forth by the Podiatrist. She provided a list of scheduled visits that indicated the Podiatrist made regular visits to the facility every other month. Further interview with the DON revealed Resident #8 had been placed on the Podiatrist list for the last scheduled visit date of 08/10/12. The DON provided a copy of this list which included Resident #8. However, the DON was unsure as to why Resident #8 was not seen by the Podiatrist on the scheduled date. She reported the facility only kept the last visit list on file and had no other list of resident podiatry referrals. The DON also reported the Podiatrist documented his care on a form that he mailed back to the facility, which would then be placed in the medical file for the resident receiving care.

Interview with Registered Nurse #2, on 10/11/12 at 1:40 PM, revealed the Podiatrist visited every eight (8) to nine (9) weeks and provided care to those residents placed on the Podiatrist list kept at the nurses station. RN #2 could not remember the last Podiatry visit in August and believed the Podiatrist may have cancelled the visit. She stated that she was also unsure of how nail/foot care was documented because she had never seen the Podiatrist make notes in the medical charts. When asked why Resident #8 was not seen by the Podiatrist, she was unaware. RN #2 did report Resident #8 may have refused care, but was unsure because refusal of Podiatry services were not usually documented.

Interview with RN #3, on 10/11/12 at 3:00 PM, revealed the Podiatrist did visit as scheduled in August but could not remember the exact date. She reported that the Podiatrist saw several residents that were on the Podiatrist referral list.

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When asked how Podiatry care was documented, RN #3 stated she believed the Podiatrist made notes that were kept at the Podiatry clinic. When asked how Podiatry refusals were documented, RN #3 stated, she believed the Podiatrist wrote it on the Podiatrist referral list, but she was not certain.

Continued interview with the DON, on 10/12/12 at 3:30 PM, revealed the Podiatrist did not document refusals of care. The DON reported she had called the Podiatry office on 10/11/12 and there was no records for Resident #8 having received or refused Podiatry care. The DON did agree that this was an area of concern and reported there needed to be some type of documentation as to why Resident #8's nail/foot care had not been addressed.

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
SS=F
The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy/procedures it was determined the facility failed to prepare, distribute, and serve food under sanitary conditions. Observations, on

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F 371
It is the policy of Carter Nursing and Rehabilitation Center to procure, store, prepare and serve food in a sanitary manner.

The employees involved in the incidents recorded on 10/10/12 received education by the Dietician on 10/10/12 regarding the proper procedure for hand washing, gloving, transporting foods within the dietary department, and serving food at the appropriate temperatures.

A review of the infection control log by the DON on October 31, 2012, revealed that no resident had been affected by this practice.

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10/10/12, revealed staff failed to properly wash their hands after touching potentially contaminated items during tray line service and failed to utilize gloves when directly touching food during food preparation. Further observation during tray line on 10/10/12 revealed as the cook passed bowls of salad over top of bowls of chili, water from the bottom of salad bowls dripped into resident's bowls of chili. In addition, the facility failed to ensure all cold foods being served were at safe holding temperatures.

The findings include:

1. A review of the facility's policy/procedure titled "Handwashing/Hand Hygiene", revised date June 2010, revealed employees must wash their hands before and after handling food.

Interview, on 10/10/12 at 1:35 PM, with the Registered Dietitian (RD) revealed they did not have a specific policy on handwashing or glove use for food service but the facility's practice was staff wash hands before the start of tray line and whenever they touched a potentially contaminated surface. In addition, staff were not supposed to touch food barehanded, but were to wear gloves.

Observation of during tray line service, on 10/10/12 at 12:10 PM, revealed Cook #1 touched counter surfaces, her clothing, and her skin, and failed to wash her hands prior to beginning tray line service. Further observation at 12:15 PM revealed Cook #1 threw away empty alcohol prep pad packets that were on a counter surface and got out an empty pan without washing hands prior to continuing the tray line. Continued

F 371 All dietary staff received additional education by the Dietitian and/or the Dietary Manager by 11/14/12 regarding appropriate protocols for storage, preparation, distribution and serving of food under sanitary conditions. This included education regarding appropriate food temperatures on the tray line.

The dietary manager will complete rounds of the kitchen three times a week for the next eight weeks and monthly thereafter to ensure dietary sanitation protocols are followed. Results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.

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observations from 12:40 PM until 12:50 PM revealed Cook #1 passed bowls of cucumber salad, taken out of an ice filled tray and passed over top of bowls of chili located on resident's trays. Further observations revealed water dripped from the bottom of the bowls as they were passed over the top of the opened bowls of chili. Additional observation, at 1:10 PM, revealed Cook #1 touched her face and failed to wash hands before continuing tray line.

Interview, on 10/11/12 at 1:25 PM, with the Cook revealed she was supposed to wash her hands prior to the start of tray line service especially after she touched counters, her skin, and her clothing to prevent possible cross contamination. Further interview revealed Cook #1 did not realize water from the bottom of the cucumber bowls dripped into the bowls of chili as she placed the salad onto resident's trays. Cook #1 stated the water dripping from the salad bowls into the bowls of chili would be possible contamination of the chili and she should not have done that.

Observation of food preparation, on 10/10/12 at approximately 12:20 PM, revealed Dietary Aide (DA) #1 took bread slices out of the package and prepared peanut butter sandwiches with her bare hands.

Interview with DA #1, at 1:25 PM, revealed staff was to wear gloves if they directly touched food. Further interview revealed she did not follow the current policy, but did wash her hands prior to handling the food.

Interview, on 10/10/12 at 1:30 PM, with the Food Service Manager revealed staff was not

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supposed to touch food barehanded. He stated DA #1 did not follow facility practice by touching the food with her bare hands. He indicated tray line staff were supposed to wash their hands before starting tray line and anytime they may touch potentially contaminated surfaces such as counter tops, their clothing, or their face when doing tray line. Further interview revealed, the water from the bottom of the cucumber bowls should not have dripped into resident's chili because of the potential of cross contamination.

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Interview with the RD, on 10/10/12 at 1:35 PM, revealed staff should not touch food with their bare hands because they could contaminate the food and staff should wear gloves when they directly touched food. The RD stated it was an infection control issue if they touched contaminated surfaces during tray line service and failed to wash their hands. Further interview revealed the cook should not have allowed water from the bottom of the cucumber bowls to drip into the bowls of chili because of infection control.

2. A review of the facility's policy/procedures: "Tray Line and Meal Service Temperatures", effective date 08/01/12, revealed it was the policy of the facility to serve food to the residents at appropriate temperatures. All cold foods would be stored at or below 41 degrees Fahrenheit (F), or at an alternate temperature designated by state law. Further review of the policy revealed all cold food items exceeding 41 degrees F would result in corrective action by the cook on duty or the dietary manager.

Observation during tray line service, on 10/10/12, revealed the following temperatures of items:

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At 11:35 AM, Pureed Pimento Cheese was 43.7 degrees F.
At 11:45 AM Cole Slaw was 44.2 degrees F.
At 12:25 PM Cucumber Salad was 45.1 degrees F.
At 12:45 PM the replacement tray of Pimento Cheese sandwich was 45.1 degrees F.

Interview with the RD, on 10/12/12 at 9:10 AM, revealed per policy all cold foods should be held at 41 degrees F or below. Further interview revealed the facility served a lot of cold items for that meal and there was not a lot of space in the refrigerators because they were already full. She stated some of the items being served contained mayonnaise (Cucumber Salad, Cole Slaw, Pimento Cheese) and there was a concern with food safety when the cold items were not held at the proper temperatures.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

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 371

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It is the policy of Carter Nursing and Rehabilitation Center to employ a licensed pharmacist to ensure proper disposition of controlled drugs, label drugs and biologicals in an accepted manner and use and store them according to accepted professional standards, have cautionary instructions, and the expiration date when applicable.

All multi-dose vials, opened items, and outdated items were discarded by the RN Supervisor on 10/10/12. The medications on the top of the medication cart were removed and discarded by the CMT on 10/10/12.

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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 review of facility's policies, it was determined the facility failed to ensure safe and secure handling of medications and biological as evidenced by twelve (12) multi-dose containers not dated as to when they were opened, twelve (12) medications which were secure closed and one (1) medication which was unsecured on top of the medicine cart in a cubby hole during med pass. In addition observations revealed expired boxes of alcohol swabs and expired culture swabs in the medication room.

The findings include:

Review of the facility's policy titled, "Medication Storage in the Facility", undated, revealed except for those requiring refrigeration, medications

F 431

A review of the monthly incident tracking log by the DON on October 31, 2012, indicated that no residents had been affected by this practice.

The ADON and RN Supervisors inspected the med carts, treatment carts and medication rooms on 10/11/12 to ensure that all items were dated and any outdated or open item was discarded.

The RN Supervisors will inspect the medication carts, treatment carts and medication supply rooms three times a week for four weeks and weekly thereafter to ensure that no infractions are noted. Any undated, outdated or opened supply will be immediately discarded.

The results of these room and cart audits will be discussed at the weekly Focus Committee Meeting and forwarded to the monthly CQI Committee Meeting for further monitoring and continued compliance.

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intended for internal use were stored in a medication cart or other designated area. Additionally, outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedures for medication disposal.

Review of the facility's policy titled "Specific Medication Administration Procedures", undated, revealed when a multi-dose container was opened that date should be placed on the item.

Observation of the North Wing's treatment cart, on 10/10/12 at 10:00 AM, revealed the following multi-dose containers opened without dates on the containers:

1. Dakin's 0.25 %
2. Sterile plain packing strip ¼ inch
3. 0.9% Normal Saline 250 Cubic Centimeter (CC) bottle
4. 70% Rubbing Alcohol
5. 0.25% Acetic Acid 250 CC bottle
6. Chlorhexidine Gluconate (Oral Rinse) 1.2 Milligram/Milliliter (MG/ML) bottle
7. Renacidin Irrigation
8. Peroxide bottle
9. Open Suture removal kit.

Observation of the South Wing's Medication Room, on 10/10/12 at 11:20 AM, revealed the following multi-dose containers opened without dates on the containers and expired biological items:

1. 0.25% Acetic Acid 250 CC bottle
2. 70% Rubbing Alcohol
3. 0.9% Normal Saline 250 CC bottle

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4. 3 boxes of alcohol swab sticks, expired 08/20/12
5. 18 culture swabs, expired 09/12

Interview with Licensed Practical Nurse (LPN) #2, on 10/10/12 at 10 AM, revealed the opened multiple use irrigations should have had an "open" date on the bottle.

Interview with Registered Nurse (RN) #1, on 10/10/12 at 10:15 AM, revealed any opened multiple use supply should be dated with the open date. Additional interview, at 11:20 AM, revealed items found in South Wing Medication Room should have been on the Treatment Cart with open date on containers. She stated the charge nurse checked the room randomly for expired items but did not have a regular schedule.

Interview with Pharmacy Technician Consultant, on 10/10/12 at 11:20 AM, revealed medication rooms were checked for expired items usually once a month.

Interview with Director of Nursing (DON), on 10/12/12 at 4:00 PM, revealed multi-dose containers should be dated when opened so that item was not left without an expiration date. She further stated it was a shared responsibility of Nursing and Nursing Supervisors to check supplies for expiration dates and ensure stock was rotated.

Observation of the medication cart on the South Wing, on 10/10/12 at 11:20 AM, revealed the following medications were stored in a rubber storage caddy on top of the medication cart:

1. 3 secured closure packets of Tylenol 500

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Milligrams (MG)

2. Secured closure packet of Sienna 8.6 MG
3. Secured closure packet of Loratine 10 MG
4. 3 secured closure packets of Ferrous Sulfate 325 MG
5. 4 Albuterol inhaler solutions, unopened
6. Unsecured closure packet of 1/2 Klor-Con M20 tablet

Interview with Certified Medical Technician (CMT) #1, on 10/10/12 at 11:20 AM, revealed she was unaware of medications on top of medication cart. CMT #1 stated medications should not have been in the caddy. CMT #1 further stated when staff was finished with their shift, staff should restock the medication carts and make sure carts were in good shape.

Interview with CMT #2, on 10/12/12 at 2:50 PM, revealed it was not appropriate to store medications on top of medication cart. She also stated if you have an unsecured closure packet, medication should be disposed in proper manner such as placed in sharps container.

Interview with Licensed Practical Nurse (LPN) #1, on 10/12/12 at 3:00 PM, revealed if you have half a medication in unsecured closure packet, medication should be wasted by placing in sharps container. She also stated all medications should be stored in medication the cart and it was not appropriate to leave medications on top of medication cart in storage caddy.

Interview with RN #2, on 10/12/12 at 3:30 PM, revealed it was not appropriate to store medication on top of the medication cart. She also stated if staff had partial medication,

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medication should be wasted.

Interview with DON, on 10/12/12 at 4:00 PM, revealed medications should be stored in the medication cart and it was not appropriate to leave medications on top of cart in a storage caddy. She also stated any unsecured closure packet should be disposed of in proper method such as placed in sharps container.

F 441 483.65 INFECTION CONTROL, PREVENT SS#E 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

F 431

F 441

It is the policy of Carter Nursing and Rehabilitation Center to establish and maintain an effective Infection Control Program.

Resident #5 received a TB skin test by the DON on 10/15/12. It was read on 10/17/12 by the DON and the results were negative.

All urinals and bedpans were labeled and placed in plastic bags by SRNA's by 10/12/12.

The RN Supervisors and Medical Records Director reviewed all admissions for the last 6 months to ensure that TB skin testing was completed timely.

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility policies it was determined the facility failed to 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.

Resident #5 was administered the Tuberculin Skin (TB) test on 01/28/12; however, there was no documented evidence the facility followed up with reading the test results.

Also, observation during initial tour revealed urinals and bed pans which were unlabeled and not bagged hanging on the hand rails in residents' bathrooms.

In addition, observation during medication pass, revealed a staff member administered medications to Unsampled Resident A, and failed to wash hands prior to exiting the room.

The findings include:

F 441
All nursing staff will receive additional education by the Staff Development Coordinator no later than 11/14/12 regarding the importance of utilizing facility protocols in regards to appropriate infection control techniques. This included hand washing and appropriate storage of urinals and bedpans.

All licensed staff received additional education by the SDC no later than 11/14/12 regarding the importance of administering the TB skin tests on new admissions as directed by facility policies. This included directions on how to proceed if a resident goes out of the facility before a skin test can be read.

The DON, ADON, SDC and RN Supervisors will monitor the infection control practices on a daily basis (M-P) via daily compliance rounds. The week-end RN Supervisor will monitor infection control practices on Saturday and Sunday.

The results of these compliance rounds will be discussed in the weekly Focus Committee Meeting and forwarded to the monthly CQI Committee Meeting for further monitoring and continued compliance.

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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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 441 Continued From page 52

1. Review of the facility's policy titled "Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests", dated June 2010, revealed the facility would administer and interpret tuberculin skin tests (TST) in accordance with recognized guidelines and pertinent regulations.

Review of the State of Kentucky's Tuberculosis Guidelines, revealed the residents were required to have yearly Tuberculosis screenings.

Review of Resident #5's medical record revealed the last documented evidence of a completed TB skin test was 06/29/11.

Interview, on 10/12/12 at 2:00 PM, with the Director of Nursing (DON), revealed the Tuberculosis Guidelines and Regulations that were referenced in the facility's policy were the State of Kentucky Guidelines and Regulations for Tuberculosis.

Interview, on 10/11/12 at 3:35 PM, with Nursing Supervisor (NS) #3 revealed Resident #5's TB skin test was administered on 01/28/12, but Resident #5 was not in the facility for the test to be interpreted. NS #3 further revealed Resident #5's TB test was not followed up on and Resident #5 did not receive the test as required by the regulations and guidelines.

2. Review of the facility policy entitled "Bedpan/Giving and Removing", revised 11/01/11, revealed after use of the bed pan, rinse with cool water to remove feces and urine, rinse pan with hot running water, remove gloves, place in a plastic bag and return to bedside cabinet or

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F 441 Continued From page 53
designated area.

F 441

Observation, on 10/09/12 at 7:15 PM, during initial tour revealed the bathrooms between resident's room 52A/52B had a bed pan lodged between the hand rail and the wall which was unlabeled, undated, and not bagged. Further observation of the resident bathroom between 51A/51B, revealed two (2) bed pans lodged between the hand rail and the wall which were unlabeled, undated, and not bagged, and a urinal hanging on the hand rail which was unlabeled, undated, and not bagged.

Interview, on 10/12/12 at 5:20 PM, with the DON, revealed bed pan and urinals were to be labeled with resident's name and date and cleansed and bagged after use.

3. Review of the facility's policy entitled "Specific Medication Administration Procedures, undated, revealed to administer medications in a safe and effective manner, staff should cleanse hands before handling medication and before contact with resident.

Observation of medication pass, on 10/10/12 at 11:00 AM, revealed CMT #1 opened the laptop computer on top of the medication cart to access electronic Medication Administration Record (MAR) of Unsampled Resident A, removed medications from packages and placed in a medication cup. The CMT then entered the resident's room, raised the head of the bed, handed the resident's water glass to the resident for a drink of water, then handed the medications to the resident. CMT #1 left the resident's room, returned to the medication cart and accessed the

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F 441 Continued From page 54

electronic MAR to document the refusal of the inhaler. During this observation, CMT #1 did not wash with soap and water nor sanitized her hands to prevent possible infection transmission.

Interview with CMT #1, on 10/10/12 at 12:15 PM, revealed she had washed her hands when she returned from break to start her medication pass. CMT #1 stated it was policy to only wash or sanitize hands between residents.

Interview with CMT #2, on 10/12/12 at 2:50 PM, revealed it was policy to sanitize or wash hands prior to handing a resident his/her medications and again after administration of medications.

Interview with LPN #1, on 10/12/12 at 3:00 PM, revealed staff should be washing hands with soap and water after physical contact with residents or residents' personal belongings. She stated if no contact, staff could use approved hand sanitizers for infection control for the next two (2) or three (3) medication passes before having to use soap and wash to disinfect hands.

Interview with RN #2 Charge Nurse, on 10/12/12 at 3:15 PM, revealed staff should be disinfecting hands at the beginning of medication pass, as well as before and after the administration of medications.

Interview with the DON, on 10/12/12 at 3:30 PM, revealed staff should be sanitizing hands anytime they have contact with a resident, or resident's belonging.

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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 III. Smoke Compartment: Five smoke compartments Fire Alarm: Complete fire alarm system. Panel upgraded in 2006. Sprinkler System: Complete automatic (dry/wet) sprinkler system. System installed in 1985. Generator: Type II A standard life safety code survey was conducted on 10/11/11. Carter Nursing and Rehabilitation Center was found not be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was one hundred twelve (112). The facility is licensed for one hundred twenty (120) beds.	K 000	11/15/12
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible	K 050	It is the policy of Carter Nursing and Rehabilitation Center that fire drills are held at least quarterly and unexpected times under varying conditions.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050 Continued From page 1
alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted at various times reflecting various conditions of the facility, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred twenty (120) residents, staff and visitors.

The findings include:

Record review of the last four (4) quarters of 3rd shift fire drills, on 10/11/12 at 2:36 PM, with the Maintenance Director, revealed all 3rd shift fire drills were conducted at 12:00 AM. The observation was confirmed with the Maintenance Director.

Interview, on 10/11/2012 at 2:36 PM, with the Maintenance Director revealed 3rd shift fire drills were always conducted at 12:00 AM and was unaware the fire drills should be conducted at various times reflecting various conditions of the facility.

Reference: NFPA 101 (2000 edition)
4.7.5* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency.
19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm

K 050

The Area Maintenance Supervisor provided education to the facility Maintenance Director on 10/12/12 regarding the importance of varying the fire drill times on all shifts

The Area Maintenance Supervisor will review facility fire drill records monthly for the next three months to ensure that fire drills are randomly conducted, as required.

This information will be discussed at the monthly CQI Committee Meeting for further monitoring and continued compliance.

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K 050 Continued From page 2
signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.
Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

K 050

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

K 072

It is the policy of Carter Nursing and Rehabilitation Center that means of egress are continuously maintained free of all obstructions or impediments.

The proper signage was placed on the exit doors by the Maintenance Director on 10/12/12.

The plant was moved away from the door in the front lobby.

The DON and Maintenance Director will educate all nursing staff no later than _____ regarding the importance of nursing staff moving the carts room to room with them and then storing them out of the hallways when not in use.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions and were clearly indicated according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred twenty (120) residents, staff and visitors.

The findings include:

Observation, on 10/11/2012 at 10:48 AM, with

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K 072 Continued From page 3

the Regional Project Manager revealed linen carts being stored in the North and South Halls. The carts were not in use and were unattended. The observation was confirmed with the Regional Project Manager.

Interview, on 10/11/2012 at 10:48, with the Regional Project Manager revealed linen carts were routinely stored in the corridors.

Interview, on 10/11/2012 at 10:48, with the Director of Nursing confirmed the linen carts were not in use and that the linen carts were routinely stored in corridors.

Observation, on 10/11/2012 at 11:07 AM, with the Regional Project Manager revealed a potted plant was blocking one (1) set of doors at the Main exit. The observation was confirmed with the Regional Project Manager.

Interview on 10/11/2012 at 11:07 AM, with the Regional Project Manager revealed he was unaware the potted plant had been placed in front of the exit doors.

Observation, on 10/11/2012 at 11:07 AM, with the Regional Project Manager revealed the two (2) sets of main exit doors did not contain the proper signage indicating the doors were equipped with delayed egress hardware. Further observation revealed one (1) set of the main exit doors had a sign that read "Please use front door." The observation was confirmed with the Project Manager.

Interview, on 10/11/2012 at 11:07 AM, with the Regional Project Manager revealed he was not

K 072

The Area Maintenance Director will observe the facility egresses at least monthly to ensure that all egresses remain clear of impediments and that appropriate signage is evident on each exit door.

These issues will be discussed monthly at the CQI Meeting for further monitoring and continued compliance.

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K 072 Continued From page 4
 aware the exit doors did not contain the proper signage and indicated the sign reading "Please use front door" was confusing.
 Reference: NFPA 101 (2000 edition)

4.5.3.3 Awareness of Egress System. Every exit shall be clearly visible, or the route to reach every exit shall be conspicuously indicated. Each means of egress, in its entirety, shall be arranged or marked so that the way to a place of safety is indicated in a clear manner.

7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayedegress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.
 (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.
 (b) The doors shall unlock upon loss of power

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K 072 Continued From page 5
controlling the lock or locking mechanism.
(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.
(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS

K 072

K 130
SS=D
OTHER LSC DEFICIENCY NOT ON 2786

K 130
It is the policy of Carter Nursing and Rehabilitation Center to all equipment is protected against damage.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure natural gas equipment was protected against possible vehicle damage, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect twenty four (24) residents, staff and visitors.

The Area Maintenance Director and the Facility Maintenance Director will install barriers around the gas regulator for protection no later than _____.

The Area Maintenance Director will observe the regulator on monthly visits for three months to ensure that the barrier installed is effective.

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K 130: Continued From page 6
The findings include:

Observation, on 10/11/12 at 11:20 AM, with the Regional Project Manager revealed the natural gas regulator located next to the parking lot area was not protected by barriers, to protect against possible vehicle damage. The observation was confirmed with the Regional Project Manager.

Interview, on 10/11/12 at 11:20 AM, with the Regional Project Manager revealed he had not noticed the gas regulator was not protected with a barrier.

Reference: NFPA 54 (1999 edition)
5.1.12 Gas Equipment Physical Protection.
Where it is necessary to locate gas utilization equipment close to a passageway traveled by vehicles or equipment, guardrails or bumper plates shall be installed to protect the equipment from damage.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure the

K 130

This information will be reviewed at the monthly CQI Committee Meeting for three months to ensure compliance and further monitoring.

K 144

It is the policy of Carter Nursing and Rehabilitation Center that our generators be inspected weekly and exercised under load for 30 minutes per month.

The generator was tested under load by the Area Maintenance Director and the facility Maintenance Director on 10/12/12 with no issues noted.

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K 144 Continued From page 7
 emergency generator was tested and documentation of testing was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred twenty (120) residents, staff and residents.

The findings include:

Record review of the facility's emergency generator test and maintenance logs, on 10/11/2012 at 2:40 PM, with the Maintenance Director, revealed the generator testing and maintenance logs did not contain documentation the emergency generator had been ran under load. The observation was confirmed with the Maintenance Director.

Interview, on 10/11/2012 at 2:40 PM, with the Maintenance Director confirmed he did not document the running of the emergency generator under load monthly. Further interview revealed he believed the emergency generator automatically switched to being under load when the emergency generator was started during its testing cycle.

Interview, on 10/11/2012 at 2:43 PM, with the Regional Project Manager revealed the emergency generator did not automatically switch to being under load when the generator was started during its testing cycle.

Reference: NFPA 110 (1999 edition)

6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the

K 144
 The Area Maintenance Director provided additional education to the facility Maintenance Director regarding the importance of testing the generator under load for 30 minutes each month.

The Area Maintenance Director will review the facility records on a monthly basis for three months to ensure that the generator is being tested under load as directed by facility policy.

This information will be discussed at the monthly CQI Committee meeting for further monitoring and continued compliance.

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2012
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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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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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following methods:
(a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating
(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer
The date and time of day for required testing shall be decided by the owner, based on facility operations.

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