

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ OCT 16 2012	(X3) DATE SURVEY COMPLETED  09/13/2012
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NAME OF PROVIDER OR SUPPLIER  CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033 Division of Health Care Southern Enforcement Branch
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F 000  F 164 SS=B	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 09/11-13/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p><b>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</b></p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 000  F 164	<p>The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and State law.</p> <p><b>F-164</b></p> <ol style="list-style-type: none"> <li>1. Resident's private information was secured immediately to provide for resident (# 8, E, F) privacy. RN #1 was counseled and reeducated immediately. (See exhibit #1, RN #1 counseling form).</li> <li>2. The Interdisciplinary Team (IDT) performed a rapid check of other nurses MARS and kardex's to determine if others had been affected by the practice. It was determined that no other residents' privacy was placed in jeopardy by this deficiency.</li> <li>3. A system review was conducted and facility policy on HIPAA was reviewed and determined to be an effective policy by the IDT. All staff was reeducated on 10/02/12 to ensure that HIPAA and confidentiality is maintained throughout the facility. (See Exhibit # 2, Sign in log &amp; agenda for In-Service on HIPAA).</li> </ol> <p>F-164 Continued on next page.....</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE ADMINISTRATOR	(X6) DATE 10/16/12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

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

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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and facility policy, the facility failed to ensure resident health information was maintained in a private and confidential manner during medication administration. Observation of medication pass on 09/12/12, revealed the Nurse Shift Report Sheet and Medication Administration Record (MAR) that contained resident health information was left open on top of the medication cart in the hallway and as a result the personal information for one sampled resident (Resident #8) and two unsampled residents (Residents E and F) was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's Residents' Rights policy (dated October 2007) revealed facility staff was responsible to maintain the confidentiality of the residents' personal and clinical records.</p> <p>Observation during medication pass on 09/12/12, at 4:10 PM, revealed Registered Nurse (RN) #1 entered Resident #8's room to administer two medications to the resident. Further observation revealed the MAR and the Nurse Shift Report, located on top of the medication cart in the hallway, was not covered and residents' personal and confidential information was exposed to anyone in the area of the hallway where the cart was located. The MAR contained a list of Resident #8's medications, diagnoses, diet order, allergies, admission date, date of birth, and the name of the resident's physician. The shift report contained residents' names and documentation of concerns with residents as told to RN #1 from the day shift nurse.</p>	F 164	<p>F-164 Continued....</p> <p>4. A quality instrument was established immediately to be performed by the D.O.N. or Administrator daily on every shift for the time period of seven days or until 100% compliance has been achieved, then varying shifts for seven days or until 100% compliance has been achieved, then weekly for three months or until 100% compliance is achieved. Finding will be reported to Quality Assurance committee for additional input. (See exhibit #3, HIPAA quality Instrument).</p>	10/02/12	

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F 164	<p>Continued From page 2</p> <p>Further observation on 09/12/12, at 4:10 PM, revealed Resident #8 requested medication for pain. RN #1 returned to the medication cart and obtained the medication. RN #1 entered Resident #8's room to administer the medication and left the MAR and Nurse Shift Report exposed to anyone that passed by the medication cart positioned in the hallway.</p> <p>At 4:20 PM, on 09/12/12, RN #1 was observed to enter resident room 118 and administered two medications to Resident E. The MAR and Nurse Shift Report were left open on top of the medication cart in the hallway and exposed the residents' private and personal information to anyone that passed by the medication cart. Several staff members and visitors were observed to walk past the medication cart while the MAR and Nurse Shift Report were left exposed. RN #1 failed to ensure confidentiality of residents' health information located on the MAR and Nurse Shift Report while she administered medications to residents.</p> <p>Further observation on 09/12/12, revealed RN #1 continued the medication pass and entered resident room 121 at 4:30 PM, to administer eye drops and three oral medications to Resident F. The MAR was observed to be open on the medication cart in the hallway with Resident F's medication sheet exposed. Further observation revealed the Nurse Shift Report remained visible to anyone that passed by the medication cart that was positioned in the hallway. The RN failed to maintain the confidentiality of the residents' personal and clinical records as mandated by facility policy.</p>	F 164		

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F 164	Continued From page 3 Interview conducted on 09/12/12, at 4:40 PM, revealed RN #1 had been trained to maintain confidentiality of residents' medical information. The RN stated the residents' personal information should be kept private in accordance with facility policy and acknowledged the MAR and Nurse Shift Report sheet should not be visible to the public. The RN stated she was nervous during the medication pass and left the residents' health information exposed.  Interview with the Director of Nursing (DON) on 09/13/12, at 10:10 AM, revealed staff should protect residents' private information during medication pass and was required to keep all information on the MAR covered during medication administration. Additionally, the DON stated the Nurse Shift Report should be kept confidential and not exposed to visitors or residents.	F 164		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Four overbed tables were observed to be chipped with rough edges. Several bedside stands were observed to have chipped edges and/or broken drawers/drawer	F 253	<b>F-253</b>  <b>1.A-</b> The over bed tables in resident rooms 103, 106, 119, and 136 were inspected immediately and made safe for the residents, edges were sanded and left smooth. (See Exhibit #4, work order repair, over bed tables)  <b>1.B-</b> Bedside stands in resident rooms 120, 136, 137, 142, and 150 were inspected immediately and made safe for the residents, edges were sanded and left smooth (See Exhibit #5, work order repair, bedside stands) bedside stands in resident rooms 120 and 136 bedside stand	

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F 253	<p>Continued From page 4</p> <p>handles. One toilet seat was observed to be unstable. Two fans were observed to be dusty and four toilets were observed to be soiled/stained.</p> <p>The findings include:</p> <p>A review of the facility's "General Environmental Conditions" policy, dated 10/01/07, revealed the facility would provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>Observations throughout the survey on 09/11/12, 09/12/12, and 09/13/12, revealed the following areas were in need of maintenance/housekeeping services:</p> <ol style="list-style-type: none"> <li>1. The overbed tables in resident rooms 103, 106, 119, and 136 were chipped with rough edges.</li> <li>2. Bedside stands in resident rooms 120, 136, 137, 142, and 150 were chipped and scratched. In addition, the bedside stands in resident rooms 120 and 136 had broken drawers/handles.</li> <li>3. The toilets in resident rooms 105, 124, 147, and 150 were observed to be soiled/stained.</li> <li>4. The raised toilet seat on the toilet in resident room 118 was observed to be loose/unstable.</li> <li>5. Two portable fans were observed to be very dusty. One fan was at the Davis Hall nurses' station and the second fan was in resident room 124.</li> </ol>	F 253	<p>F- 253 Continued....</p> <p>Were repaired immediately.(See <b>Exhibit #6, work order repair bedside stands, drawers/handles</b>).</p> <p><b>1. C.</b> The toilets in resident rooms 105, 124, 147, and 150 were immediately cleaned or replaced. (See <b>Exhibit #7, work order clean or replace toilet seats</b>).</p> <p><b>1. D.</b> The raised toilet seat on the toilet in resident room 118 was removed and replaced with an appropriate fitting with stable legs and arm rests. (See <b>Exhibit #8, work order removal and replacement of unstable seat</b>).</p> <p><b>1. E.</b> The two portable fans were immediately cleaned by housekeeping.</p> <p><b>2. A.B.C.D.E.</b> A rapid inspection was performed by Housekeeping, Maintenance and Administrator (See <b>Exhibit # 9, Updated environmental inspection tool</b>) to determine if there were any other residents that were being affected by the potentially deficient practice. Other areas that were found in need were repaired or cleaned immediately.</p> <p><b>3. A.B.C.D.</b> Over Bed tables, bed side stands, and cleanliness/safety of toilet seats were added specifically to the environmental audit which will be conducted on a weekly basis by the housekeeping staff. (See <b>Exhibit # 9, Updated environmental inspection tool</b>). All Housekeeping staff were re-educated on how to utilize the environmental audit tool on 10/15/12.</p> <p><b>E.</b> A weekly fan cleaning schedule was established by housekeeping to ensure the routine cleaning of fans in the facility (See <b>Exhibit # 10, fan inspection sheet</b>).</p>	

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F 253	Continued From page 5 An environmental tour was conducted with the Maintenance Supervisor (MS) and the Housekeeping Supervisor (HS) on 09/12/12, at 2:00 PM. Both supervisors stated they made frequent rounds to check for cleaning and maintenance needs and failed to observe the areas noted to be in need of repair.	F 253	F-253 Continued..... E. A weekly fan cleaning schedule was established by housekeeping to ensure the routine cleaning of fans in the facility (See <b>Exhibit # 10, fan inspection sheet</b> ).		
F 282 SS=D	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/procedure it was determined the facility failed to ensure staff provided care to residents in accordance with the resident's written plan of care for one of sixteen sampled residents (Resident #4). Resident #4 was assessed as at risk for the development of pressure sores and had a care plan intervention for turning and repositioning every two hours. Observation on 09/11/12 and 09/12/12 revealed the resident was not turned and repositioned in accordance with the care plan.  The findings include:  Review of the facility policy/procedure, "Care Plan, Interdisciplinary," dated as reviewed 10/01/11, revealed individualized	F 282	4. A.B.C.D.E A <u>continuous</u> monthly Quality Assurance monitor will be performed by Administrator to evaluate the effectiveness of the environmental tool. Any issue discovered will be promptly addressed and reported to the QA Committee for direction and input. (See <b>Exhibit # 9, Updated environmental inspection audit</b> ).  F-282  1. Resident #4 was immediately assessed for any skin break down and an attempt was made to turn and reposition, however resident #4 refused to comply or allow anyone to turn her. A turning and repositioning schedule was added to the Treatment Administration Record (TAR) and to resident Kardex. After resident #4 was reeducated to the need for turning and repositioning and continued to refuse, a non compliant Care Plan was enacted at this time.  2. An immediate audit was conducted by the IDT, to ensure that <u>all</u> Care Planned information was carried over to the residents Kardex, special attention was given to ensure that any resident in which a Turning and Repositioning Program was Care Planned, was added to the TAR and Kardex.	10/16/12	

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F 282	<p>Continued From page 6 .</p> <p>approaches/interventions the staff would take to assist the resident to reach the goals identified by the interdisciplinary team would be identified and written into the care plan. Further review of the policy/procedure revealed the care plan was a guide for all staff to ensure a decline in the resident's status was avoided if at all possible.</p> <p>Review of the medical record of Resident #4 revealed the facility admitted the resident on 08/08/11 and readmitted the resident on 07/27/12 after an acute hospital stay. Review of the comprehensive assessment for Resident #4 dated 06/25/12 revealed the facility had assessed the resident to require extensive assistance of two staff persons for bed mobility and to be at risk for pressure ulcers. At the time of the assessment the resident had a Stage 2 pressure ulcer to the coccyx. Review of the quarterly assessment for Resident #4 dated 08/23/12 revealed the resident remained at risk for the development of pressure ulcers but had no current pressure ulcers.</p> <p>Review of the comprehensive care plan for Resident #4 dated as revised on 09/14/11, revealed the resident had the potential for altered skin integrity. The goal was for the resident to have intact skin with no breakdown and one of the interventions was for staff to turn and reposition the resident every two hours. Staff was to conduct right and left rotations and the resident was to be on his/her back only for meals.</p> <p>Review of the Treatment Record for Resident #4 dated July 2012 revealed instructions to turn and reposition the resident every two hours to the right and the left only. Review of the Treatment</p>	F 282	<p><b>F-282 Continued.....</b></p> <p>3. An Admission/Readmission Team (ARAT) was formed under the Quality Assurance Committee for the sole purpose of reviewing changes in the plan of care for each resident that is readmitted from hospital or is admitted to the facility. (See Exhibit # 11, Admission/Readmission Team Policy). An Assurance of Care policy was revised to assure that the Care plan/ Kardex items are being completed as ordered. (See Exhibit 11-A, Assurance of Care Policy).After the initial audit of all residents, 10% of the facility census will be randomly audited by the charge nurse weekly, utilizing the Validation of Care tool within the Assurance of Care Policy, for a period of three months longer if less than 100% compliance is not achieved to ensure ordered care is being provided. Then monthly, by the Unit supervisor for a period of not less than one year.</p> <p>4. ARAT will log and report any pattern of discrepancies monthly to the QA committee. (See Exhibit #11-B, ARAT Log). The DON will review Unit Supervisors Validation Tools responses to identify if there are any breakdown in the provision of care to the residents and report findings on a <u>continual basis</u> to the QA Committee monthly for review and direction.</p> <p><b>F-282 continued on next page.....</b></p>		

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F 282	<p>Continued From page 7</p> <p>Record for August 2012 and September 2012 revealed no instructions to turn and reposition the resident. Review of the Certified Nursing Assistant (CNA) Kardex for Resident #4 revealed no instructions for staff to turn and reposition the resident every two hours.</p> <p>Observations were conducted on 09/11/12, at 2:30 PM, 3:00 PM, 3:30 PM, 4:00 PM, 4:55 PM, and 5:50 PM, and on 09/12/12, at 8:48 AM, 9:30 AM, 10:15 AM, 11:00 AM, and 1:00 PM. During each observation Resident #4 was positioned in bed on his/her back.</p> <p>An interview was conducted on 09/12/12, at 1:10 PM, with CNA #2. The CNA confirmed she was responsible for the care of Resident #4 on 09/12/12. The CNA stated staff followed the resident's Kardex for care needs. According to CNA #2, if the resident required turning and repositioning every two hours it would be on the Kardex.</p> <p>Interview with the Unit Manager for the Raley Hall on 09/13/12, at 9:30 AM, revealed care needs on the resident's care plan would be carried over onto the CNA Kardex. According to the Unit Manager, CNA staff utilized the Kardex to identify each resident's care needs. The Unit Manager stated staff documented on the Treatment Record that the care had been provided.</p> <p>Interview with the Director of Nursing (DON) on 09/12/12, at 12:50 PM, revealed Resident #4 should have been turned and repositioned every two hours in accordance with the care plan. According to the DON, the resident had been to the hospital multiple times in July and the</p>	F 282	<p>F-282 Continued.....</p> <p>...The DON directing the ARAT will be responsible for the assurance that the Care Plan information is correctly transcribed to the Kardex by means of review with each residents care plan conference held every week.</p>	10/16/12

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F 282	Continued From page 8 requirement for turning and repositioning had not been carried over onto the treatment record for August and September.	F 282	<b>F-314</b> <b>1.</b> Noted: resident #4 to be on an alternating pressure reduction mattress. Resident #4 was immediately assessed for any skin break down and an attempt was made to turn and reposition, however resident #4 refused to comply or allow anyone to turn her. Resident #4 was promptly re-educated as to the need for turning and repositioning and to the potential for skin breakdown and ulcers to develop if continued noncompliance. A turning and repositioning schedule was added to the Treatment Administration Record (TAR) and to resident Kardex to ensure that attempts were continually made to turn and reposition along with reeducation. After resident #4 was reeducated to the need for turning and repositioning and continued to refuse, a non compliant Care Plan was enacted at this time.  <b>2.</b> An immediate audit was conducted by the IDT, through the use of Braden scores and skin Assessments (See Exhibit # 11-C, Braden scoring and skin assessment tool) and to identify any residents that had the potential to have been affected by the deficient practice in conjunction, Care Planned information was also reviewed for all residents in the facility to ensure that interventions were carried over to the residents Kardex, special attention was given to ensure that any resident in which a Turning and Repositioning Program was Care Planned, was added to the TAR and Kardex if indicated.	
F 314 SS=D	<b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy/procedure, it was determined the facility failed to ensure one of sixteen sampled residents (Resident #4) received necessary treatment/services to promote healing or to prevent the development of new pressure sores. Resident #4 was assessed to be at risk for the development of pressure sores and had a care plan intervention for turning and repositioning every two hours. Staff failed to turn and reposition the resident on 09/11/12 and 09/12/12 in accordance with the resident's comprehensive plan of care in an effort to prevent the development of pressure sores.  The findings include:  Review of the facility policy/procedure, "Pressure Ulcers," dated as revised 05/10/12, revealed the	F 314		

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F 314	<p>Continued From page 9</p> <p>facility would provide treatment to residents to prevent formation of a pressure ulcer. Further review of the policy/procedure revealed the facility would ensure all residents at risk for pressure ulcers were identified and given care to prevent the development of pressure ulcers.</p> <p>Review of the medical record of Resident #4 revealed the facility admitted the resident on 08/08/11 and readmitted the resident on 07/27/12 after an acute care hospital stay. Review of the comprehensive assessment for Resident #4 dated 06/25/12 revealed the resident required extensive assistance of two staff persons for bed mobility and activities of daily living. Further review of the assessment revealed the resident had a pressure ulcer to the coccyx. Review of the quarterly assessment for Resident #4 dated 08/23/12 revealed the resident continued to require extensive assistance of two staff members for bed mobility and activities of daily living. The quarterly assessment identified the resident to be at risk for the development of pressure ulcers and the previous pressure ulcer to the resident's coccyx had healed.</p> <p>Review of the comprehensive care plan for Resident #4 dated 09/14/11 revealed the resident had the potential for altered skin integrity and an intervention was developed for staff to turn and reposition the resident every two hours, right and left rotations, on his/her back only for meals.</p> <p>Observations were conducted on 09/11/12, at 2:30 PM, 3:00 PM, 3:30 PM, 4:00 PM, 4:55 PM, and 5:50 PM, and on 09/12/12, at 8:48 AM, 9:30 AM, 10:15 AM, 11:00 AM, and 1:00 PM. During each observation Resident #4 was positioned in</p>	F 314	<p><b>F-314 Continued.....</b></p> <p><b>3. All residents are assessed on admission and quarterly by use of the Braden Skin Assessment Tool to identify any resident with the potential to have under gone any physiological changes that would indicate a need for the update in the residents Plan of Care. (See Exhibit # 11-C, Braden scoring and skin assessment tool). An Admission/Readmission Team (ARAT) was formed under the Quality Assurance Committee for the sole purpose of reviewing changes in the plan of care for each resident that is readmitted from hospital or is admitted to the facility. (See Exhibit # 11, Admission/Readmission Team Policy). An Assurance of Care policy was revised to assure that the Care plan / Kardex items are being completed as ordered. (See Exhibit 11-A, Assurance of Care Policy). An initial audit of all residents, 10% of the facility census will be randomly audited by the charge nurse weekly, utilizing the Validation of Care tool within the Assurance of Care Policy, for a period of three months longer if less than 100% compliance is not achieved to ensure ordered care is being provided. Then monthly, by the Unit supervisor for a period of not less than one year.</b></p> <p><b>F-314 Continued on next page.....</b></p>		

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F 314	<p>Continued From page 10 bed on his/her back.</p> <p>Review of the Treatment Records for Resident #4 for July revealed staff had documented the resident had been turned and repositioned every two hours until 07/22/12. There was no documentation for August or September to indicate staff had turned and repositioned the resident every two hours. Review of the Certified Nursing Assistant (CNA) Kardex for Resident #4 revealed no documentation to indicate the resident required turning and repositioning every two hours.</p> <p>Interview on 09/12/12, at 1:10 PM, with CNA #2 revealed she was responsible for the care of Resident #4 on 09/12/12. According to CNA #2 all the resident's care needs were on the CNA Kardex and staff followed the Kardex. CNA #2 stated if the resident required turning and repositioning every two hours then that requirement would be on the Kardex and the Treatment Record.</p> <p>Interview on 09/13/12, at 9:50 AM, with CNA #3 revealed she cared for Resident #4 frequently. According to CNA #3 if a care need was not on the CNA Kardex staff would not know the care was required. CNA #3 stated the care needs would also be on the Treatment Record for staff to document completion.</p> <p>Interview with the Director of Nursing (DON) on 09/12/12, at 12:50 PM, revealed the resident's Treatment Record should contain documentation of turning and repositioning. According to the DON, Resident #4 was admitted to the acute care hospital multiple times in July 2012. The DON</p>	F 314	<p><b>F-314 Continued.....</b></p> <p>4. ARAT will log and report any pattern of discrepancies monthly to the QA committee. (See Exhibit #11-B, ARAT Log). In addition, the DON, utilizing the Validation of Care Tool located within the revised Assurance of Care Policy (See Exhibit 11-A, Assurance of Care Policy). The DON will review Unit Supervisors Validation Tools responses to identify if there are any breakdown in the provision of care to the residents and report findings on a <u>continual basis</u> to the QA Committee monthly for review and direction. The ARAT will be responsible for the assurance that the Care Plan information is correctly transcribed to the Kardex by means of review with each residents care plan conference held every week.</p>	10/16/12	

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F 314	Continued From page 11 stated Resident #4 should be turned and repositioned every two hours in accordance with the resident's plan of care; however, the requirement for turning and repositioning had not been carried over onto the Treatment Record after the resident returned from the hospital in July.	F 314			
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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: Based on observation, interview, and record review, it was determined the facility failed to ensure the residents' environment remained free of accident/hazards. Observation of medication pass on 09/12/12 revealed RN #1 used large scissors to open individual medication packets and left the large scissors unsecured/unattended on the medication cart.  The findings include:  Review of the policy titled Accident and Falls Committee, dated as reviewed 10/01/11, revealed the facility would ensure resident safety and prevention of accidents and falls through risk assessment, identification, and monitoring	F 323	<b>F-323</b> <b>1. RN #1 was reeducated on not leaving dangerous items unsupervised. (See Exhibit # 12, RN #1 Counseling)</b> <b>2. The IDT swiftly performed an inspection and reeducation of all nurses and work stations that were currently providing care to the residents. There were no other infractions discovered.</b> <b>3. All staff were re-educated on Cedars Safety and Accident policy to determine areas of education that were lacking that may be attributed to preventing an accident free culture at cedars, (See Exhibit # 13, retraining log: accidents and incidents), before they were allowed to perform work in the facility.</b> <b>4. The IDT wishes to inspire an accident free safe culture among its staff and residents. A quality instrument will be used to evaluate the work areas and the facility as a whole on every shift for the period of one month, longer if less than 100% compliance is met. The charge nurse assigned to each wing will be responsible for performing this shift monitor. A monthly monitor will be performed at random by the ADON to determine if further education or counseling needs to take place. The monitor will be reported to The QA Committee on a monthly basis for input and direction. (See Exhibit # 14, Environmental Safety Monitor).</b>	9/21/12	

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F 323	<p>Continued From page 12 implementation of interventions.</p> <p>Observation of medication pass on 09/12/12, at 4:20 PM, on the Raley Hall revealed RN #1 used large scissors with pointed ends to open two individual medication packets for Resident #8. RN #1 was observed to enter Resident #8's room and left the large scissors unsecured/unattended on top of the medication cart in the hallway.</p> <p>Further observation on 09/12/12, at 4:15 PM, revealed RN #1 returned to the medication cart to prepare two medications for unsampled Resident E. RN #1 used the large scissors to open the individual medication packets. RN #1 entered resident room 118 and left the large scissors unsecured/unattended on top of the medication cart. Several staff members, a visitor, and one resident were observed to be in the hallway near the medication cart while the scissors were left unsecured/unattended on top of the medication cart.</p> <p>Continued observation of medication pass on 09/12/12, at 4:30 PM, revealed RN #1 used the large scissors to open three individual medication packets for unsampled Resident F. RN #1 entered resident room 121 and administered the medications to the resident. Observation revealed the large scissors remained unsecured/unattended on top of the medication cart in the hallway.</p> <p>Review of the facility's list of residents that were assessed as having wandering behaviors revealed one resident on the Raley Hall had been assessed to wander. Observation revealed the resident resided three rooms from where RN #1</p>	F 323			

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F 323	Continued From page 13 had positioned the medication cart.  Interview conducted on 09/12/12, at 4:40 PM, with RN #1 revealed she was knowledgeable of scissors being a hazard to residents and was required to keep the scissors secured in a drawer of the medication cart or in her pocket. RN #1 stated she just failed to ensure the scissors were secured and not accessible to residents or anyone that was near the medication cart.  Interview with the DON on 09/13/12, at 10:10 AM, revealed residents should not have access to scissors or any hazards. The DON stated staff was required to keep scissors in a medication drawer or the nurse's personal pocket.	F 323			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	<b>F-431</b>  A. All loose or unlabeled pills were immediately removed from the carts and pharmacy was notified to assist in the identification before discarding the pills. B. The Medication carts were positioned outside of the storage room indicated. Pharmacy was contacted and advised of the drug Ceftriaxone that was located on the cart in the storage area with substandard temperature. Pharmacy immediately replaced the Ceftriaxone to ensure freshness and quality. Residents that had received any of the medications were evaluated for any adverse reactions, there were no adverse reactions noted.		

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F 431	<p>Continued From page 14 controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, it was determined the facility failed to store medications according to acceptable professional principles. The area on the Raley Hall designated as the medication cart storage area was observed to be 84 degrees Fahrenheit and the refrigerator for medication storage was observed to be 52 degrees Fahrenheit. In addition, two loose, unpackaged pills were found in two different medication carts.</p> <p>The findings include:</p> <p>A review of the facility's Medication Storage policy, dated 10/01/07, revealed medications were to be stored in compliance with accepted standards. The policy further stated medications with storage requirements for temperature controls must be stored to meet those specifications. In addition, when refrigerators were used to store temperature sensitive</p>	F 431	<p>F-431 Continued</p> <p>C. Medication located in the refrigerator in question were immediately removed and placed in an appropriate functioning refrigerator, Pharmacy notified and a representative came into facility and made appropriate replacements to the medications that were affected. Residents that had received any of the medications were evaluated for any adverse reactions, there were no adverse reactions noted.</p> <p>2. A., B., C., An immediate evaluation was completed by the IDT to determine the residents that were affected by the deficient practice. Those that were affected were evaluated for any adverse reactions. There were no adverse reactions noted.</p> <p>3. A., B. The IDT evaluated the process involving medication storage and dispensing. It was determined that the licensed staff, before the start of a medication pass, will check all compartments of the cart for loose, unlabeled or unwrapped pills/medications. This will be performed immediately following the narcotic count.</p>	

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F 431	<p>Continued From page 15</p> <p>Medications, a daily temperature log was to be maintained on the refrigerator.</p> <p>Observations of the medication storage areas/carts on 09/13/12, at 11:50 AM, revealed the following:</p> <ol style="list-style-type: none"> <li>1. A loose, unwrapped/unlabeled pill was observed inside a drawer on the "down ramp" Davis Hall cart and in the Raley Hall cart #2.</li> <li>2. The medication cart storage area on the Raley Hall was observed to be 84 degrees Fahrenheit at 12:00 PM on 09/13/12. There were 8 vials of Ceftriaxone which, according to the manufacturer's label, must be stored between 68 and 77 degrees Fahrenheit.</li> <li>3. The medication storage refrigerator on the Raley Hall was observed to be 52 degrees Fahrenheit at 11:55 AM on 09/13/12. According to documentation on the refrigerator temperature log, staff failed to obtain the temperature of the refrigerator since 09/11/12, a timeframe of two days. Medications stored in this refrigerator included insulin and suppositories.</li> </ol> <p>An interview with the Director of Nursing on 09/13/12, at 1:10 PM, revealed the DON was not aware the storage area was too warm for medication storage. The DON further stated the medication refrigerator control had accidentally been dialed to the warmer temperature and when she reset it, it cooled right away.</p>	F 431	<p>F-431 Continued.....</p> <p>...the nurse will document on a quality instrument covering the cleanliness of cart, loose/unlabeled medications and storage temperature of medications (See Exhibit #15, <b>Cart quality instrument</b>).</p> <p>C. The refrigerator was evaluated and it was determined that unit required defrosting to ensure proper function. After the unit was defrosted it performed as it was intended by the manufacturer, returning to the temperature range required for the safe storage of medications.</p> <p>4. A., B., C., A quality instrument will be used to evaluate the loose pills, cart storage temps and refrigerator temperature/defrost on a continual basis. (See Exhibit #15, <b>Cart quality instrument</b>). A schedule for defrosting/temp. Monitoring log was established. (See Exhibit # 16, <b>refrigerator, cart cleaning monitor</b>). The tasks will be performed by each nurse in charge of a med cart; unit coordinator will be responsible for monitor frig. Temp and third shift charge nurse will defrost unit This will be monitored by the ADON daily for one month for accuracy, longer if less than 100% compliance is achieved. Findings will be reported to QA committee for evaluation and input.</p>	9/21/12

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F 441 SS=D	Continued From page 16 <b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F-441  <b>1. Resident #8 was immediately evaluated for any adverse affects of the unclean medication .The resident suffered no immediate effects and was monitored for any adverse affects to the medication. RN #1 was counseled and reeducated immediately. RN #1 was also mandated to attend a "Proper medication administration" in-service provided at the facility by MedCare Pharmacy.</b>  <b>2. The IDT educated and interviewed RN #1 and all other licensed staff. There were no other deficient practices noted.</b>  <b>3. IDT determined that although the occurrence was with one nurse, it would benefits all licensed staff to undergo retraining. An intensive retraining program was made mandatory for all licensed staff. (See Exhibit #17, MedCare In-service sign in log and agenda).</b>  <b>4. A quality instrument will be utilized by the DON, ADON, or Administrator to perform random medication administration audits on all shifts for one month or until 100% compliance is achieved. Pharmacy will then perform in-depth review monthly and report to QA monthly.(See Exhibit # 18, med. Admin, audit)</b>	10/02/12	

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F 441	<p>Continued From page 17</p> <p>Based on observation and interview it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of sixteen sampled residents (Resident #8). Observation of medication pass on 09/12/12 revealed staff failed to administer medications in a sanitary manner. Staff was observed to administer a medication to unsampled Resident A that had been dropped onto the top of the medication cart.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 09/13/12, at 10:10 AM, revealed the facility did not have a policy related to medications that were dropped. However, the DON stated any tablet that was dropped would be considered soiled and should be discarded and another tablet obtained from the resident's medication stock.</p> <p>Observation of medication pass on 09/12/12, at 4:10 PM, revealed RN #1 obtained a Hydrocodone tablet from the medication cart's locked narcotic drawer. RN #1 positioned the card containing multiple Hydrocodone tablets over a medication cup and pushed the Hydrocodone tablet thru the package for the tablet to drop into the medication cup. During the attempt to place the Hydrocodone tablet in the medication cup, RN #1 dropped the tablet onto the top of the medication cart. RN #1 used the medication cup to scoop the tablet into the medication cup but had to push the tablet against a clipboard that was on top of the medication cart to get the tablet into the medication cup. RN #1</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>CEDARS OF LEBANON NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>337 SOUTH HARRISON STREET LEBANON, KY 40033</b>		
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F 441	Continued From page 18 entered Resident #8's room and administered the dropped/soiled medication to the resident.  During interview with RN #1 on 09/12/12, at 4:40 PM, the RN acknowledged any medication that was dropped should be discarded and another tablet obtained from the medication drawer. RN #3 stated she was nervous and should not have administered the dropped tablet to the resident.  Interview on 09/13/12, at 10:10 AM, with the DON, revealed the nurse should have discarded the medication that had been dropped onto the top of the medication cart and obtained another tablet for the resident.	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a sanitary environment. Observation of the four facility medication carts revealed two of the carts contained pill/paper debris and soiled, sticky substances.  The findings include:  An interview with the Director of Nursing on 09/13/12, at 1:10 PM, revealed there was no facility policy concerning cleanliness of the medication carts.	F 465	F-465  1. The carts were cleaned, sanitized and inspected immediately, by the nursing staff operating the carts.  2. In considering the issues associated with the deficient practice it was deemed that all the residents had the potential to have been affected.  3. A policy was developed with pharmacy assistance to ensure the medication carts were clean and sanitary at all times (See Exhibit #19, medication administration cart cleaning policy). All licensed staff was in serviced and educated by pharmacy on 10/02/12. (See Exhibit #17, MedCare In-service sign in log and agenda).  F- 465 Continued on next page.....		

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F 465	Continued From page 19  Observations on 09/13/12, at 11:50 AM, revealed the "down ramp" Davis Hall and the Raley Hall medication carts were soiled with sticky substances inside the drawers and there was pill/paper residue built up in the corners.  An interview with Licensed Practical Nurse #5 on 09/13/12, at 12:00 PM, revealed she believed the night shift staff was supposed to clean the medication carts, however, there was no documentation/evidence this was done.	F 465	F- 465 Continued.....  IDT established a quality instrument to be utilized by each licensed personnel to ensure cart is sanitized before administering medications to residents. (See Exhibit # 16, refrigerator, cart cleaning monitor).  4. The DON will randomly monitor carts on all shifts for one month or until no less than 100% compliance is achieved. Then monthly for three months or until no less than 100 % compliance is achieved. Findings will be reported to QA committee for input and direction.	10/02/12	

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NAME OF PROVIDER OR SUPPLIER  CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 37 SOUTH HARRISON STREET LEBANON, KY 40033			
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K 000	INITIAL COMMENTS  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type III (000)  SMOKE COMPARTMENTS: 4  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (wet & dry) sprinkler system.  GENERATOR: Type II propane generator.  A life safety code survey was initiated and concluded on 09/12/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000				
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	K 025				

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



TITLE  
ADMINISTRATOR

(X6) DATE  
10/05/12

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 025	<p>Continued From page 1</p> <p>floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected three of four smoke compartments, staff, and approximately sixty residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/12/12, at 11:10 AM, with the Director of Maintenance (DOM) unsealed penetrations of electrical wiring, holes, and water piping were observed in the attic and above suspended ceilings in the Raley, Davis, and Davis up-ramp fire/smoke barrier walls. In a fire situation, unsealed penetrations of fire/smoke barriers aid in the spread of smoke and fire to other parts of the building. The facility was cited for the same deficient practice on 10/06/11. An interview with the DOM on 09/12/12, at 11:10 AM, revealed contract work takes place in these places after he leaves for the day and no one tells him. The DOM was unsure of which walls should be maintained as Fire/smoke barrier walls.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 025	<ol style="list-style-type: none"> <li>The Director of Maintenance (DM) was immediately counseled and reeducated as to the location of all fire/smoke barriers in the facility on 09/12/12 (See Exhibit # 23, DM Counseling and reeducation form). The unsealed penetrations of electrical wiring, holes, were repair immediately on 09/12/12 utilizing appropriate fire rated caulking. This included water piping in the attic, above suspended ceilings in the Raley and Davis Hall. The Davis Hall up-ramp Fire/smoke barrier Walls were repaired utilizing appropriate fire rated drywall.</li> <li>The Interdisciplinary Team (IDT) determined that the deficient practice had the potential to have affected all residents in the facility.</li> <li>An addition was made to the Hazardous areas surveillance quarterly inspection to inspect all fire/smoke barriers for continuity. (See Exhibit # 24, Hazardous areas surveillance 2012). DM was educated and in serviced on 09/12/12. (See Exhibit # 23, Counseling and reeducation form).</li> <li>The fire / smoke barriers will be inspected for cracks, gaps, penetrations etc monthly by DM for no less than 6 months or until all potential issues are identified and corrected and findings reported to QA Committee. ( See Exhibit # 24, Hazardous areas surveillance 2012)</li> </ol>	10/19/12	

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K 025	Continued From page 2  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures	K 025			

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K 025	Continued From page 3 composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected three of four smoke compartments, staff, and approximately fifty residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.  The findings include:  During the Life Safety Code survey on 09/12/12, at 10:05 AM, with the Director of Maintenance (DOM) mismatched temperature rated sprinkler heads were observed in the Davis Hall. Sprinkler heads must be properly matched to ensure proper operation of the sprinkler system. An interview with the DOM on 09/12/12, at 10:05 AM, revealed the DOM was not aware of this requirement. During the survey the kitchen,	K 062	<b>K-062</b>  1. B & B Fire Safety was immediately contacted to perform an inspection of the sprinkler heads in question within the three smoke compartments. Replacement began immediately on the mismatched heads.  2. Determination was made by IDT that in fact, approximately 50 residents had the potential to be affected by the deficient practice.  3. The contracted company that installed the mismatched sprinkler heads was discontinued.  4. A quality instrument was initiated by the IDT ( <b>See Exhibit # 24, Hazardous areas surveillance 2012</b> ) to be conducted quarterly and after any sprinkler system work is performed by contracted vendors. This monitor will be reported to QA on a quarterly basis, monthly when necessary.	<b>10/19/12</b>	

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K 062	Continued From page 4 smoke room, and the Raley Hall were also observed to have mismatched sprinkler heads.	K 062		
K 072 SS=D	Reference: NFPA 13 (1999 Edition). 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.  NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected one of four smoke compartments, staff, and approximately twenty residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.  The findings include:  During the Life Safety Code tour on 09/12/12, at 10:05 AM, with the Director of Maintenance (DOM) a plastic chain was observed near the	K 072	<b>K-072</b>  1. All plastic chains were removed immediately from all doors and corridors in the facility. 2. The DM quickly made inspections of all resident doorways and corridors. The residents that had requested the plastic chains were educated to reasons as to why they would be removed. There were no other Velcro attached plastic chains noted in any other corridors within the facility. 3. The IDT enacted a policy that provided for the assurance of egress by the DM on a daily basis. (See Exhibit 25, Egress daily monitoring by DM policy) This is to be reported by DM every morning in the Continual Quality Improvement meeting. (Morning Meeting) 4. IDT implemented an egress inspection to be conducted on a daily basis for one month or until 100 % compliance has been obtained, longer if necessary. Then continually on a monthly basis. Findings are to be reported to the QA committee for input and direction. (See Exhibit # 14, General environmental safety inspections)	09/25/12

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K 072	Continued From page 5 Davis down-ramp fire doors. An interview with the DOM revealed the chain would be placed across the corridor to prevent a wandering resident from going to this area of the building. The DOM stated that he knew this was a deficient practice and that the surveyor should speak to Administration about it. During the survey, chains were also observed at resident room doors. The facility was cited for impeding egress with chains on the 10/06/11 life safety code survey.	K 072		
K 144 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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 interview, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected four of four smoke compartments, staff, and all the residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.  The findings include:  During the Life Safety Code survey on 09/12/12, at 10:45 AM, an interview with the Director of Maintenance (DOM) at the generator set revealed the DOM was not aware the generator transfer	K 144	<b>K-144</b>  1. The generator was placed under load and the transfer switch was tested immediately for functionality. The generator and switch performed flawlessly. The DM was immediately counseled and reeducated to the operation of the generator and the transfer switch.(See Exhibit # 23, DM counseling and retraining) 2. Given the nature of the stated deficient practice, IDT determined that all residents had the potential to have been affected. 3. A specific policy was developed for generator maintenance and testing. (See Exhibit # 26, Generator maintenance and testing policy). The DM was in serviced on 9/21/12. 4. A quality monitor was developed for the maintenance and testing of the generator to be performed on a weekly basis for three months or longer if necessary until 100% compliance has been achieved. Then monthly by the DM and reported to the QA Committee.(See Exhibit #27, Generator quality monitor)	09/21/12

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K 144	Continued From page 6 switch should be exercised and logged once a month. This test helps ensure the generator transfer switch is operating properly.  Reference: NFPA 110 (1999 Edition).  6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected four residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.  The findings include:  During the Life Safety Code tour on 09/12/12, at 10:10 AM, with the Director of Maintenance (DOM) a nebulizer, oxygen concentrator, and electrical bed cord were observed to be plugged into a multi-outlet adapter (power strip) in resident room 137. Generally power strips with surge	K 147	K-147  1. All medical equipment was removed from power strips in room 106 and 137 immediately and connected to appropriate outlets. 2. All resident living areas were inspected for the use of power strips by the DM; no other issues of compliance were discovered. 3. The General Environmental Safety inspection form will be utilized to determine areas of concern. A monthly inspection will be performed by the DM for any non compliance issues. <b>(See Exhibit # 14, General environmental Safety Monitor).</b>		

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NAME OF PROVIDER OR SUPPLIER  <b>CEDARS OF LEBANON NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>337 SOUTH HARRISON STREET LEBANON, KY 40033</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 7 protection may be used for resident TVs, computers, radios, etc., on an as needed basis but not to be used with medical equipment or high-draw appliances to help prevent against electrical shock and fire. An interview on 09/12/12, at 10:10 AM, with the DOM revealed the DOM thought special power strips could be used with medical equipment. During the survey resident rooms 106 and 137 were also observed to be using medical equipment with power strips.  Reference: NFPA 99 (1999 Edition).  3-3.2.1.2 D  2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K-147 Continued.....  4. A monthly inspection will be performed by the DM monthly on a continuing basis for any non compliance issues. (See Exhibit # 14, Environmental Safety Monitor). The Director of Maintenance will report findings to the QA Committee on a monthly basis for direction and input.	09/21/12	