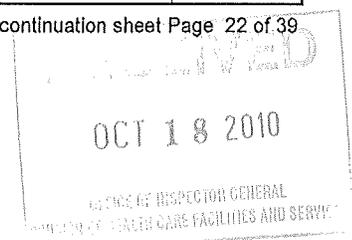


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/23/2010
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 21 and she met with the family. The resident expired on 09/03/10.</p> <p>Review of the care plan revealed the facility failed to revise the resident's care plan to address the resident's changing condition and provide social service programs.</p> <p>Interview with the Social Services Designee (SSD) on 09/23/10 at 2:00pm, revealed she did review the care plan to ensure residents received comfort care. She stated she would provide emotional support and a minister. She was unable to provide any evidence that the residents' care plans were revised with interventions to meet the resident's needs for terminal conditions.</p> <p>Review of the clinical record for Resident #1 revealed the resident was admitted with diagnoses of Dementia, Dysphagia, and Parkinson's Disease. The facility completed a quarterly MDS assessment on 08/13/10 which revealed the resident had a moderate impairment in the ability to make daily care decisions and required extensive assistance with all care needs. Review of nursing notes for 08/08/10, revealed the resident was grabbed by the collar by another resident. Resident #1 responded by smacking the other resident. On 08/12/10, the resident was noted to be kicking at another resident during the meal service. Review of the care plan revealed the facility failed to revise the care plan to address this behavior.</p> <p>Interview with the SSD on 09/23/10 at 2:00pm revealed she did not address behaviors. She stated there used to be a behavior nurse in the past who did care planning; however, the nurse no longer worked at the facility. She stated she</p>	F 280	<p>those residents on Comfort Measures are having their wishes honored.</p> <p>These audits will be reported to the facility QA Committee for review.</p>		

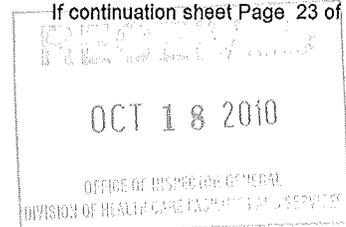


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F 280	Continued From page 22 had received training on behaviors; however, she just did not address them. Record Review for Resident #15 revealed the resident was to receive education on dietary and fluid restrictions as well as a dietician recommendation not to have tomatoes. However, review of the care plan revealed there was no documentation of the resident's education on 09/02/10 or the recommendation by the dietician. Interview on 09/23/10 at 3:00pm with the LPN, Unit Coordinator, revealed that the care plan was not updated when the resident had fluid volume complications and did not know the care plan should be updated. Interview on 09/23/10 at 3:35pm with the Director of Nursing revealed that the Unit Coordinator would educate the patient and update the care plan and document in the nurse's note or interdisciplinary notes.	F 280	Resident #12 was educated by the SSD on 10/19/10 about the importance of following his fluid restrictions the resident voiced understanding and this was documented in the medical record. All dialysis resident's will have their care plan reviewed by 10/25/10 to ensure the care plan reviewed to include monitoring of fluids and shunt. Nursing staff were inserviced on 10/15/10 by the DON regarding procedures for monitoring the fluid restrictions and for shunt care for any resident undergoing dialysis. Staff were re-educated on the practice of entering all fluids consumed by the resident into CareTracker for accurate documentation and review. Dialysis residents have fluids reviewed daily to ensure they are meeting fluid restrictions. Fluid restrictions have also been placed on tray card. A card comes with beverage cart showing staff how many cc's dialysis residents are allotted per meal.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to	F 309		

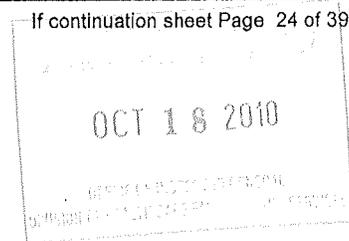
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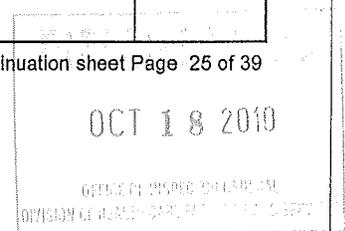
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F 309	<p>Continued From page 23</p> <p>monitor and assess a dialysis shunt and consistently monitor the fluid restriction of one (1) dialysis resident (#12) of the twenty-two (22) sampled residents. Resident #12 did not have a Treatment Administration Record (TAR) developed to document the assessment of the shut utilized for dialysis. In addition, the facility did not have accurate and consistent documentation of the resident's intake. The facility allowed the resident to have a water pitcher in the room and was not educated on the potential outcomes of non-compliance with the fluid restriction.</p> <p>The findings include:</p> <p>Review of the facility's policy provided by the nursing department revealed, Chapter 21, pages 698, 699 and page 702 of the Lippincott Manual, 2001, Seventh Edition, titled RENAL AND URINARY DISORDERS, under the heading Continues Ambulatory Peritoneal Dialysis; indicated the procedure, requirements, methods, complications and monitoring during Hemodialysis treatments. It also included the lifestyle management for Chronic Hemodialysis.</p> <p>1. Dietary management involves restriction or adjustment of protein, sodium, potassium, or fluid intake (a renal diet and fluid restriction); 2. Ongoing health care monitoring includes careful adjustment of medications that are normally excreted by the kidney or are dialyzable; 3. Surveillance for complications (interventions on the plan of care): Arteriosclerotic Cardiovascular Disease, Congestive Heart Failure, Disturbance of Lipid Metabolism, Coronary Heart Disease, Stroke; Intercurrent infection; Anemia and Fatigue; Gastric ulcers and other problems; Bone problems; Hypertension; and Psychosocial</p>	F 309	<p>Facility water pictures have been removed from rooms as well. If a resident exceeds their recommend amount staff will review those restrictions with them. Licensed staff were educated on 10/15/10 by ADON regarding the monitoring of the shunt for any resident undergoing dialysis, this was added to the resident care plan and was placed on the TAR for appropriate documentation</p> <p>The ADON will monitor TAR's for all residents undergoing dialysis to ensure that monitoring the shunt is on the TAR and being signed as completed. This review will occur weekly for 4 weeks then monthly to ensure compliance. Results of audits will be reviewed by QA Committee.</p>		



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F 309	<p>Continued From page 24 problems.</p> <p>Record review for Resident #12 revealed an admission date of 09/16/10 with diagnoses of End Stage Renal Disease, Diabetes, Hypertension, Congestive Heart Failure, Cirrhosis of Liver, Hypothyroidism, Anxiety, Depression and Insomnia. The admission physician orders dated 09/16/10 indicated the resident was to receive a regular diet with 2000 cc fluid restriction. The initial plan of care dated 09/16/10 indicated the resident was on a regular diet, a fluid restriction of 2000 cc and receiving dialysis 3 days a week on M-W-F. There was no evidence of interventions on the plan of care to direct staff in the care of the dialysis resident. There was no evidence of interventions for the assessment or monitoring of the dialysis shunt (a device implanted usually in the upper arm to access the circulatory system during treatment). There was no evidence of interventions to instruct staff in providing and monitoring the fluid intake. There was no evidence of interventions for the provision of a water pitcher or education to the resident on noncompliance.</p> <p>Review of the nursing assistant care plan dated "Sept. 10" indicated the resident was receiving a regular diet. There is no evidence the facility had recorded the physician's ordered fluid restriction, no instruction of the amount of fluids the nursing assistant was to provide nor how they were to monitor the resident's fluid intake. The facility revised the plan of care on 09/17/10 detailing a change in the diet to; no added salt and no concentrated sweets; however, there was no evidence of any other changes made.</p> <p>Interview with Certified Nurse Aide (CNA) #6, who</p>	F 309			



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F 309	<p>Continued From page 25</p> <p>was assigned to the care of Resident #12, on 09/23/10 at 10:25am revealed they are made aware of fluid restrictions by the nurse. The CNA stated the nursing assistants complete a fluid restriction sheet for cc per meal, med pass and prn (as needed) every shift and the nursing assistant should total the amount after each meal so the resident does not go over the restricted amount. The resident should not have a water pitcher in their room because they could fill it from the sink and staff would not know the true amount of water ingested. In addition, the CNA stated that if the nursing assistant fills the pitcher they would look at how much was given but this may not be accurate. As for this resident the CNA knew the resident was compliant with the restriction. However, the CNA did not have a fluid restriction sheet for documentation but would have recorded the information in the computer. The CNA could not voice the cc restriction for Resident #12.</p> <p>Interview with CNA #7, who was assigned to the care of Resident #12, on 09/23/10 at 10:35am revealed they receive report regarding fluid restrictions. The CNA keeps track of what the resident eats and drinks then enters the information in the computer (care tracker). It is reported to the nurse if the resident goes over the restricted amount. The CNA stated Resident #12 does not go over the amount but did not know if the resident is compliant with the restriction or not and could not voice the cc restriction for this resident. The CNA went on to state that if the resident was compliant it would be fine for them to have a water pitcher and if not then the resident should not have a water pitcher. In addition, the CNA stated Resident #12 is alert and oriented and could say how much he drank.</p>	F 309			

OCT 18 2010

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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F 309	<p>Continued From page 26</p> <p>Normally the nurse would tell them if the resident could have a water pitcher; however, the CNA was not sure if the nurse had instructed the staff to place a water pitcher at bedside and had not asked.</p> <p>Additional review of the clinical record revealed the assessment of the shunt was not documented on the MAR (medication administration record), TAR (treatment administration record) or the nurse's notes. There was no evidence a shunt assessment form was utilized by the facility. The Nutrition Assessment dated 09/20/10 indicated the resident was on a 2000cc restriction with recommendations for Consistent Carbohydrate, Renal diet. There was no evidence of a plan by dietary detailing how much fluid would be provided by dietary and nursing. The meal tickets dated for 09/23/10 indicated the resident was on a 2000cc restriction but not how much the dining room staff were to provide the resident with each meal.</p> <p>Interview with the Dietary Manager (DM) on 09/22/10 at 3:55pm revealed Resident #12 was admitted to the facility on a 2000cc fluid restriction and a regular, no added salt, no concentrated sweet diet. Resident #12 would be placed on the Nutritional at Risk; however, the resident has not been seen by this committee as of yet, 7 days after admission. The DM indicated Resident #12 had a water pitcher in their room and there was coffee available on the units. In addition, since the resident ate in the dining room he received coffee and 2% milk if he requested it. At lunch the resident received buttermilk and water, as water was placed at all seating's in the dining room. At supper the resident received sugar free tea and lemonade as requested. All drinks are</p>	F 309			

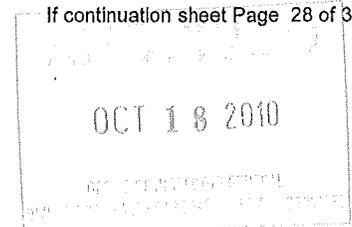
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DEPT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 27 served in an 8oz glass in the dining room. This would total 1440cc per day. The DM stated the dietary department had not received anything to change the fluid restriction to 1500cc or change the diet to a renal diet. The facility provided fluid restriction intake records for two of the eight days of stay. The 09/17/10 and 09/19/10 fluid record provided were partially completed indicating the resident's intake on 09/17/10 was 480cc at 8:00am; 355cc at 5:00pm; 120cc at the supper meal for a total intake of 955cc. The intake record printed from the computer revealed the resident's intake on 09/17/10 was 1410cc. The 09/19/10 intake record revealed 330cc at breakfast; 720cc at lunch and 120cc with morning medication pass. In addition, 240cc at 5:00pm and 360cc with supper and 120cc with evening medication pass for a total of 1890cc. The computerized intake for 09/19/10 revealed the resident exceeded the 2000cc fluid restriction by 550cc. Review of the vital sign record revealed the resident's blood pressure on 09/18/10 was 170/56 on the 11-7 shift, 220/86 before dialysis and 130/70 after dialysis. Review of the Dialysis Report Sheet dated 09/17/10 from the dialysis center indicated the resident's blood pressure prior to treatment was 170/79 and resulted in a complication during treatment due to a large fluid gain between dialysis treatments causing hypotension (a low blood pressure of 106/63). It also indicated a recommendation that the 2000cc fluid restriction be decreased to 1500cc daily. However, there is no evidence that it was acted upon by the facility. A dialysis report sheet dated 09/20/10 indicated the resident's blood pressure prior to dialysis treatment was 193/82 and a	F 309			



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F 309	<p>Continued From page 28</p> <p>complication of low blood pressure (99/50) with high fluid gain and "need restrictions on fluid please!" There was no evidence the facility acted on the concern. Review of the hand written history and physical dated 09/17/10 by the attending physician did not reveal any knowledge of the concerns expressed by the dialysis company regarding the low blood pressures or the recommendation to decrease the fluid restriction to 1500cc.</p> <p>Observations of Resident #12 on 09/21/10 at 6:45am, 10:35am, 1:30pm and 2:20pm revealed the resident up and about the room and facility per self. In addition, it was noted there was a water pitcher in the resident's room on the bedside table. On 09/22/10 while the resident was out of the facility at dialysis there was a water pitcher in the room on the bedside table.</p> <p>Interview with LPN #2, assigned to the care of Resident #12, on 09/22/10 at 4:05pm revealed Resident #12 went to dialysis on M-W-F. Dialysis sends back a form with vital signs, weight and fluids or meds provided. If no concerns are noted on the dialysis form, it goes on the chart and if there are concerns then the physician is called. The LPN stated the shunt is assessed and documented every day in the nurse's notes, medication administration record (MAR), or the treatment administration record (TAR). However, review by the LPN of the nurse's notes, MAR and TAR revealed no evidence the documentation had occurred and there was no TAR ever prepared for Resident #12. The resident was to be on intake and output to make sure the resident did not go over the restricted amount. The nursing assistants have this to record and will ask how much water was given with medication pass.</p>	F 309			

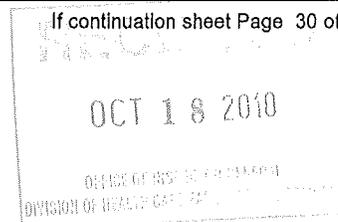
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CENTERS FOR MEDICARE & MEDICAID SERVICES
DIVISION OF HEALTH CARE DELIVERY AND SERVICES

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

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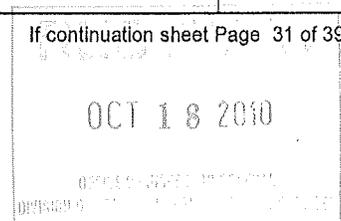
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F 309	<p>Continued From page 29</p> <p>The LPN was surprised to know a water pitcher was in the resident's room and stated the resident could get water without staff knowledge. The LPN voiced surprise that the fluid restriction was not on the plan of care.</p> <p>Interview with LPN #1 on 09/22/10 at 5:00pm revealed the water pitcher should not be there and had been removed this day and the dialysis request for 1500cc had been clarified by the attending physician after surveyor intervention.</p> <p>Re-interview with LPN #1 on 09/23/10 at 10:45am revealed dialysis sends back a form after treatment. It goes to the nurse's station and whoever is there, nurse or CMT, checks the sheet. If there are any recommendations the physician is called and the form is placed in the physician's book. The information is then disseminated to dietary and the nursing office. In addition, the nursing assistants are given the information in report and placed on the CNA careplan. Dietary calculates fluids for meals and nursing supplies the rest. The LPN was surprised to know this had not been done. If the resident is alert and oriented and can follow direction, they can have a water pitcher. However, the nurse has to discuss with the resident the potential outcome. The LPN did not know if the resident had been compliant with the restriction and did not know if this had been discussed with the resident. The potential for the resident when the physician is not notified or the fluid intake is not monitored could result in fluid overload, high blood pressure, stroke and kidney damage. The LPN indicated the treatment sheet for documentation of the shunt assessment was made yesterday 09/22/10, six (6) days after admission. In addition, the LPN stated without a</p>	F 309			



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F 309	Continued From page 30 treatment sheet and no evidence of documentation on the MAR or in the nurse's notes, the assessment of the shunt had not been done. Interview with the MDS (Minimum Data Set) nurse on 09/22/10 at 11:20am revealed no involvement in the initial assessment of the resident. The MDS nurse had been made aware of the resident's non-compliance with the fluid restriction and developed a careplan for this today, 7days after admission. When resident's are on fluid restriction, dietary gets involved and calculates the number of cc's for each department. However, she was not sure if this had been done as there had been no involvement by the MDS team. In addition, there was no assessment form used for dialysis residents. The resident should be educated on why they were on a fluid restriction and non-compliance should be reported to the dialysis unit on the communication form. However, there was no information on the dialysis forms related to noncompliance. Interview with Social Services #1 and #2 on 09/23/10 at 2:00pm revealed Social Services was a resident advocate and did so by going over the careplan in the care plan meetings and talking to the residents. In addition, they would consider non-compliance with a fluid restriction a medically related need for Social Service intervention. However Social Services #1 had not spoken to Resident #12 regarding noncompliance with the fluid restriction. Social Service #2 stated they had spoken to Resident #12 on 09/22/10, six (6) days after admission, to address the non-compliance with the fluid restriction.	F 309			
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			



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F 371	<p>Continued From page 31</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure staff hair was completely covered, ready to eat food was handled in a sanitary manner, and equipment maintained in the freezer to prevent ice formation on stored food containers.</p> <p>The findings include: Record view on 09/23/10 revealed according to Environmental Sanitation/Infection Control Policy 9.1 #2. A hair restraint that effectively covers head and/or facial hair (moustache and/or beard), is worn in food preparation areas. Hair is arranged to prevent contamination of food, equipment and utensils. Observation on 09/21/10 at 6:50am in the Main Dining Room revealed Laundry/Housekeeping Director serving food (placing food on plates) to residents while their hair was not completely covered by the hair restraint.</p>	F 371	<p>Housekeeping manager was inserviced on 9/24/10 by Administrator in regards to hair net.</p> <p>Lyons Mecahnical Service is coming to the facility on 10/15/10 to look at the pipe in the freezer. Any recommendation to repair will move forward.</p> <p>Staff education was provided on 10/15/10 by DSM(Dietary Service Manager) regarding Sanitary food handling with emphasis on hand washing, covering of all hair and use of hand coverings to touch all food that is to be consumed.</p> <p>RD (Dietary Manager) will observe meal service daily 5 days per week for one month (to include at least one breakfast, lunch and dinner weekly) to ensure the use of hair nets and that staff are using hand coverings when touching food that is to be consumed.</p>	<p>10-25-10 10-26-10</p>

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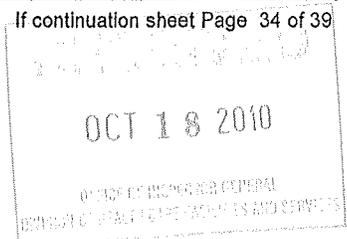
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 371	Continued From page 32 Interview on 09/23/10 at 11:00am with the Dietary Manager revealed that he was not aware that the Laundry/Housekeeping Director had not completely covered her hair. He stated not to do so was against policy and could serve as contamination to residents' food. Observation on 09/21/10 at 7:55am in the Pink Dining Room revealed Certified Nursing Assistant (CNA) #8 buttering toast for an un-sampled resident with her bare hands. Interview on 09/23/10 at 11:00am with Dietary Manager revealed staff should not handle ready to eat food with bare hands due to the possibility of contaminating residents' food. Observation on 09/23/10 at 10:45am revealed the freezer in the kitchen area had a pipe running from the fan that had been leaking water and a large amount of ice had formed on the pipe under the fan and had dripped down and formed ice on boxes of food in the freezer and on the floor. Interview on 09/23/10 at 10:45am with Dietary Manager revealed he thought ice dripping from the pipe was due to the defrost cycle. He revealed there could be a problem with cross contamination of the food due to the dripping water and ice formation.	F 371	RD will include observations of use of hair nets and hand coverings on her monthly audit of sanitation in the kitchen. Conduct audits monthly to ensure staff have hair covered in food areas. Any deficient area will be corrected immediately Safety Committee will monitor the freezer monthly to ensure it is not leaking. Any deficient area will be corrected immediately. Audits conducted by the RD and Safety Committee will be presented to the facility QA Committee for review.	
F 372 SS=F	483.35(f)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 372	The dumpster that was leaking was replaced on 10-1-10 All other dumpsters were inspected by Housekeeping Supervisor on 10/1/10 to ensure they were not leaking	10-26-10

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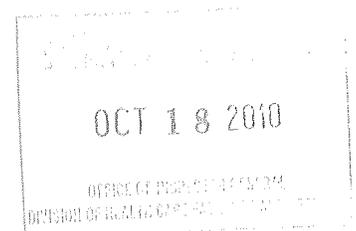
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F 372	Continued From page 33 Based on observation and interview it was determined the facility failed to dispose of garbage and refuse properly as evidenced by one of three dumpsters behind the facility leaking a white milky substance. The findings include: Observation on 09/23/10 at 10:45am revealed three dumpsters located in the back of the facility. One of three dumpsters was leaking a milky looking liquid substance which ran approximately twenty-five (25) feet down the driveway into a grassy area. The asphalt between the dumpster and grassy area was covered with stains. Interview on 09/23/10 at 10:45am with the Dietary Manager revealed he was aware there had been problems. He stated the leaking dumpster could result in problems with flies as well as rodents.	F 372	The safety committee has added checking the dumpster area for leaking to their monthly audit, ensuring that the area is reviewed monthly. The audits from the Safety Committee are reviewed by the facility QA Committee.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the refrigerator on the blue nurse's unit was maintained in a safe operating condition as there was no thermometer in the refrigerator to accurately check the refrigerator temperature. The findings include:	F 456	A thermometer was placed in the unit refrigerator on 10/1/10 by DSM. Staff inservice was done on 10/15/10 by the DSM in regards to checking refrigerator and logging temperatures and the importance of ensuring the temperatures are no greater than 40 degrees. Temperatures will be checked daily by DSM and recorded	10-25-10 10-26-10



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F 456	Continued From page 34 Record review did not reveal a facility policy for staff checking refrigerator temperatures. Observation on 09/23/10 at 8:15am revealed the refrigerator located in the dining area adjacent to the blue nurse's station did not have a thermometer. Numerous juices and individual milk cartons, ready to serve, were stored in the refrigerator. Observation of the refrigerator temperature check off sheet located on the door of the refrigerator had numerous days identified where staff had not obtained a temperature. The check off sheet had two hand written notations on two separate days which stated there was no thermometer. Interview on 09/23/10 at 8:30am with the Administrator revealed it is the responsibility of the nurses to check the temperatures daily. He stated the responsibility of the Administrator is to ensure temperatures are being done. In addition, he further stated that there is a risk for food borne illness if temperatures are above 46 degree Fahrenheit because food could spoil. He stated he just realized that he did not have a policy for the refrigerators at the nursing units dining areas.	F 456	Audits will be done weekly by DSM to ensure a thermometer is in place and the log sheet is being filled out. Any deficient area will be corrected. Audits of will be reviewed by sub committee monthly the QA Committee will review for no less than 3 months to ensure compliance.		
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 it was	F 465			



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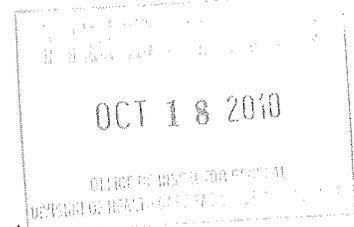
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F 465	<p>Continued From page 35</p> <p>determined the facility failed to ensure a safe, clean, comfortable and homelike environment as evidenced by soiled floors, resident's lounge furniture soiled and/or torn, mobility bars wrapped with foam and secured with tape, wheelchairs repaired with tape and/or wrapped in foam with tape. In addition, grime in both the blue and pink nursing unit men's shower rooms was observed.</p> <p>The findings include:</p> <p>Observation on 09/22/10 revealed black particles, lint, and pieces of paper on the floor located between the legs of a Hoyer lift sitting between room 101 and 103.</p> <p>Interview on 09/22/10 at 11:10am with the Housekeeping/Laundry Director revealed, "the floor needed to be cleaned and mopped and looks like it was swept up to the Hoyer lift".</p> <p>Observation on 09/22/10 at 10:52am revealed dull colored and streaked flooring throughout the hallways of all areas of the building floors.</p> <p>Interview on 09/22/10 at 10:55am with the Maintenance Director #1, revealed the floors had not been stripped in a year. The last time the floors were stripped was about this time last year; a company was hired to perform the floor stripping. All other years prior to last year, the floors were stripped and done by maintenance, but then maintenance was told to hold off by Administration because new flooring was in the budget for this year.</p> <p>Interview on 09/23/10 at 3:30pm with the Administrator revealed, maintenance was informed not to strip the floors because new</p>	F 465	<p>Hoyer lift was cleaned on 9/22/10.</p> <p>Dirt was swept up when brought to staffs attention.</p> <p>A stripping and waxing schedule is in place and is to be completed by 11/7/10.</p> <p>Chairs by blue unit nurses station were removed on 9/22/10.</p> <p>Couch on blue unit was removed on 10/11/10.</p> <p>Tape on the wheelchairs were removed on 9/22/10.</p> <p>A new lap buddy was ordered 10/11/10.</p> <p>Foam was removed from all transfer handles on 9/22/10.</p> <p>Vents were taken down and cleaned on 10/15/10.</p> <p>Hoyer lifts have been added to the cleaning schedule for housekeeping. The schedule is monitored weekly by the housekeeping supervisor.</p>	<p>10-26-10</p>
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F 465	<p>Continued From page 36 facility flooring was in the budget.</p> <p>Observation on 09/22/10 at 11:00am and 11:30am revealed the Hoyer lift on the 200 hall had dried white particles on the lift bar and black and white particles at the base of the lift.</p> <p>Interview on 09/22/10 at 11:00am with the Housekeeping/Laundry Director, revealed the Hoyer lift did not look clean and could use some germicidal cleaner.</p> <p>Interview on 09/22/10 at 11:30am with the Director of Nursing (DON), revealed she was unsure who cleans the Hoyer lift. The DON indicated this was a risk for infection.</p> <p>Observation on 09/21/10 at 08:10am revealed two (2) upholstered chairs adjacent to the blue nurse's station with brown and gray stains on the foam which was exposed from torn material on the chair arm rests.</p> <p>Interview on 09/22/10 at 10:58am with the Housekeeping/Laundry Director revealed the arms of the chairs and exposed foam did not look clean. The Director also stated the chairs could hold germs and could pose a risk for residents to become ill.</p> <p>Observation on 09/21/10 at 08:10am revealed a large yellow colored area on the blue couch adjacent to blue nurse's station.</p> <p>Interview on 09/22/10 at 11:05am with the Housekeeping/Laundry Director revealed the discoloration on the couch, "looks like some kind of stain, it does not look clean, it needs to be cleaned".</p>	F 465	<p>The cleaning of the transfer handles has been added to the cleaning schedule and is also monitored weekly by the housekeeping supervisor.</p> <p>Facility furniture will be monitored monthly by housekeeping supervisor monthly for stains, rips or tears.</p> <p>Safety Committee will monitor the lap trays monthly to ensure they are not torn. Any corrective action will take place immediately.</p> <p>Results of cleaning schedules and monitoring by Safety Committee will reviewed by sub committee monthly the QA Committee will review for no less than 3 months to ensure compliance</p>	

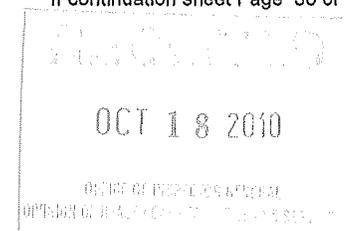
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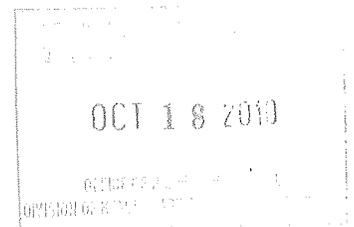
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F 465	<p>Continued From page 37</p> <p>Observation on 09/21/10 revealed one (1) lap buddy with tape on the top and corner and four (4) wheelchairs had various types of tape wrapped either on the handles or the sides of the wheelchair.</p> <p>Observation on 09/22/10 at 12:00pm revealed thirty-three (33) total residents had mobility bars padded with foam and taped.</p> <p>Interview on 09/22/10 at 10:00am with the Physical Therapist who stated, " something small that needs to be taped up, then therapy will do it".</p> <p>Interview on 09/22/10 at 11:20am with the DON, revealed there is no way of keeping taped and padded wheelchairs clean. There is a risk of infection with placing tape on the wheelchairs. Also, foam and tape on beds absorb germs and is a risk for infection.</p> <p>Interview on 09/22/10 at 11:45am with the Housekeeping/Laundry Director, revealed Housekeeping is responsible for sanitizing the bed and the transfer bars.</p> <p>Interview on 09/22/10 at 11:48am with the LPN Unit Coordinator, revealed she was not sure that any of the side rails for transfer had ever been changed out when a new resident comes in, indicating that was a risk for infection. She had always assumed housekeeping was wiping down the foam padded and taped transfer bars.</p> <p>Observation on 09/23/10 at 11:10am and 11:12am revealed four vents around the pink nurse's station and four vents around the blue nurse's station had accumulated black particles</p>	F 465	



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F 465	Continued From page 38 around the outside of the vents. Interview on 09/23/10 on 11:15am with the Maintenance Director revealed the vents were black. He was not sure when the vents were last cleaned. The director would have to check the computerized task alert system which notified maintenance when it was time to clean the vents. He revealed if the vents are not cleaned, it could potentially make residents sick.	F 465			



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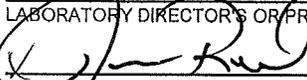
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
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K 000	INITIAL COMMENTS	K 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey on 09/23/10, it was determined the facility failed to ensure that no combustible decorations or curtains were used in the facility, according to NFPA standards. The findings include: Observation during the tour of the building, on 09/23/10 from 8:00am through 11:00am with the Maintenance Staff, revealed eighteen (18) resident rooms with hanging decorations on the doors. The resident rooms were numbered 104, 105, 106, 107, 108, 204, 205, 207, 307, 308, 310, 407, 410, 502, 504, 703, 704, and 705. Observation on 09/23/10 at 11:00am with Maintenance Staff also revealed curtains in resident rooms numbered 102, 204, and 707. Interview with Maintenance Staff on 09/23/10 at 11:00am, revealed they were unaware of the requirement that these decorations had to be treated for flame retardant. Further interview with	K 073	Fire retardant spray was received 10/14/10 and maintenance staff will have all deficient areas corrected by 10/25/10. Once wreaths are sprayed a red tag(sticker) will be applied to the back of the wreath/curtain. The Safety Committee will monitor monthly on their rounds to ensure any new item that a family/resident brought in has been sprayed. Results of Safety Committee audits will be reviewed by QA Committee.	10-26-10 10-26-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Schmitt	(X6) DATE 10-15-10
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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.

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K 073	Continued From page 1 Maintenance staff also revealed the curtains in these three rooms had not been treated for flame retardant. NFPA Standard NFPA 101.2000 Edition 19. 7. 5. 4 Combustible decorations and curtains shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073			

If continuation sheet Page 2 of 2
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