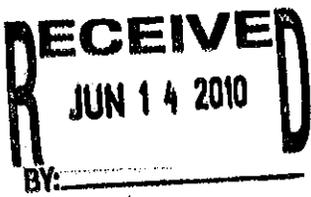


DEPARTMENT OF HEALTH AND HUMAN SERVICES.  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification survey was conducted on 04/06/10 - 04/08/10 and a Life Safety Code survey was conducted on 04/06/10. Deficiencies were cited with the highest Scope and Severity (S/S) being and "E".	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.  The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156		F156 483.10 (b)(5)-10, 483.10 (b)(1) NOTICE OF RIGHTS, RULES, SERVICES CHARGES  1. No residents were known to have been affected by this deficiency because all residents receive a "Notice of Rights, Rules, Services And Charges" upon admission. 2. No other residents were known to be affected by this deficiency because all residents receive a "Notice of Rights, Rules, Services And Charges" upon admission 3. A copy of this information was obtained and properly displayed in the facility lobby on 4/8/10 by Terry Powers, Administrator. All residents receive written "Notice of Rights, Rules, Services and Charges upon admission. 4. Monthly inspections by Facility Administrator, Terry Powers or designee to ensure proper posting of this information will be conducted.

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

TITLE

(X6) DATE

*[Signature]* Administrator 6/10/10

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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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508
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F 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These</p>	F 156		

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F 156	<p>Continued From page 2</p> <p>requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to display written information related to how to apply for the use Medicare and Medicaid benefits. Observation during the first and second day of survey failed to reveal evidence this information was displayed.</p> <p>The findings include:</p> <p>Observations on 04/08/10 and 04/07/10 revealed no evidence the facility had posted information on how residents could apply and use Medicare and Medicaid benefits.</p> <p>Interview on 4/07/10 at 11:45 AM with the facility</p>	F 156		

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F 156	Continued From page 3 Administrator revealed he was unaware the information was not posted regarding how to apply for and use Medicare and Medicaid benefits. He stated the information had been posted but had to be removed due to repairs around June, 2009.	F 156			
F 281 SS=E	483.20(k)(3)(l) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure assessments for the use of slide rails were completed for three (3) of twelve (12) sampled residents (Residents #5, #6, and #8) and failed to develop an Initial Care Plan sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and Comprehensive Care Plan for four (4) of twelve (12) sampled residents (Residents #4, #5, #6, #7, #8).  Additionally, the facility failed to ensure Physician Orders for lab services were followed for Resident #6, related to an order for a daily Prothrombin and International Normalized Ratio (PT/INR).  The findings include:  1. Review of the clinical record revealed Resident #5 was admitted to the facility on 03/28/10 with diagnoses which included Total Left Hip Arthroplasty, History of Spinal Fusion and	F 281	F281 483.20 (k)(3)(l) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1. Residents #5, 6 and 8 were known to be affected by this deficiency, resource nurse reviewed above residents charts and care plan was updated. 2. A review of all residents charts and care plans was conducted by Director of Nursing and Resource Nurse and care plans were updated. 3. A review of the policy entitled "Use of restraints and protective devices" (Exhibit 1) by Teresa LeMaster, RN., Director of Nursing and Terry Powers, Administrator indicated no need for policy revision. The current slide rail assessment form was reviewed by Director of Nursing and Administrator and changes made (Exhibit 2) to reflect the use of positioning devices. An in-service for all licensed staff, (Exhibit 3) given by Teresa LeMaster, Director of Nursing on 5/6/10 which included proper form completion and care planning for residents.	5/7/10	

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F 281	<p>Continued From page 4</p> <p>History of Falls. The Admission Assessment dated 03/26/10 revealed the facility assessed Resident #5 as being at risk for falls.</p> <p>Observations on 04/06/10 at 10:40 AM and 4:30 PM revealed two (2) upper half side rails were in the up position on Resident #5's bed.</p> <p>Review of the Side Rail Assessment dated 03/26/10 revealed two (2) upper half side rails were recommended for Resident #5. However, the assessment revealed no documented evidence to indicate the reason for the resident's use of the side rails.</p> <p>Review of the Initial Care Plan dated 03/26/10 revealed the facility noted the resident as having impaired mobility. Interventions failed to include the use of the two (2) upper half side rails.</p> <p>In addition, review of Resident #5's Physician Order's dated 03/30/10 revealed an order for a bed alarm for safety related to night time confusion.</p> <p>Observations on 04/06/10 at 10:40 AM and 4:30 PM revealed two (2) upper half side rails were in the up position on Resident #5's bed. Interview with Resident #5, at that time, revealed the bed alarm was in the top drawer of the bedside table. The resident stated the nurse placed the bed alarm on the bed at night. Observation revealed the resident's bed did not contain a working bed alarm. Further observation revealed the bed alarm connection was observed to be in the top drawer of the bedside table.</p> <p>Review of the Initial Care Plan dated 03/26/10 revealed the facility assessed the resident as</p>	F 281	<p>4. Director of Nursing or designee will conduct audits (Exhibit 4) of new admits to ensure proper care planning of repositioning devices and side rail assessment is properly completed. This will be done weekly x three months. Then once monthly an audit will be completed on new admits and in-house residents x six months.</p> <p>A quarterly report to be given to QI committee (which consists of Medical Director, Director of Nursing, Administrator, MDS Coordinator, Social Workers, Infection Control Nurse and Therapy Coordinator) for monitoring and any necessary changes.</p> <p>F281 483.20 (k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>1. Residents #4, 5, 6,, 7 and 8 were known to be affected by the deficiency. Resource nurse reviewed and updated care plans for the above mentioned residents.</p> <p>2. A chart audit of all residents care-plans was conducted by the Director of Nursing and the Resource nurse and all residents care plans were updated.</p>	

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F 281	<p>Continued From page 5 being a fall/safety risk. Interventions failed to include the use of a bed alarm.</p> <p>Further review of the Nursing Admission Assessment dated 03/26/10 revealed the facility assessed Resident #5 as having a problem with sleep and rest.</p> <p>Review of the Physician's Order dated 03/29/10 revealed an order for Ambien (a sedative/hypnotic) as needed for sleep.</p> <p>Review of the Initial Care Plan revealed the Care Plan failed to include the use of hypnotic medication.</p> <p>Interview on 04/10/10 at 12:00 PM with Licensed Practical Nurse (LPN) #2 revealed he was the resource nurse on 04/12/10 assigned to complete Resident #5's care plan. He indicated the resident's Side Rail Assessment was incomplete and the Side Rail Assessment should have included the reason for the resident's use of the side rails.</p> <p>Continued interview with LPN #2 revealed the resident's Initial Care Plan should have included interventions for the use of side rails, bed alarm and hypnotic medication.</p> <p>2. Review of the medical record revealed Resident #8 was admitted to the facility on 04/02/10 with a diagnosis which included a Left Total Knee Surgery.</p> <p>Review of the Physicians's Order dated 04/02/10 revealed an order for Wellbutrin (a psychotropic medication). Continued review of the Physician's Orders dated 04/04/10 revealed an order for</p>	F 281	<p>3. A review of the policy C08 "Care Planning" (Exhibit 5) by the Director Of Nursing, Teresa LeMaster and Administrator, Terry Powers, indicated no need for any policy revision. An in-service (Exhibit 6) by Director of Nursing was given to all licensed staff on 5/5/10 which discussed care plan policy and proper care planning of all residents.</p> <p>4. Each shift the primary nurse will update the care plan according to any changes in the residents condition or any new orders received that shift. The primary nurse will then note on order sheet at the end of her shift care planning has been completed. Care planning audits will be conducted by the Resource nurse using "Chart Audit Form" (Exhibit 7) on each new admission to ensure that care planning has been completed on all admitting orders and patient's initial assessment condition. A care plan audit (Exhibit 8) will be conducted by Director of Nursing, or designee completed weekly for three months then monthly for six months to ensure proper care planning on all residents. A quarterly report will be presented to QI committee for continued monitoring and corrective action when indicated.</p>		

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F 281	<p>Continued From page 6</p> <p>Ativan (a psychotropic medication).</p> <p>Review of the Initial Care Plan dated 04/02/10 revealed no documented evidence the facility care planned Resident #8 related to the use of the psychotropic medications.</p> <p>Interview on 04/08/10 at 12:30 PM with LPN #2 revealed he was responsible for Resident #8's care plan. He indicated the resident's care plan should have included the use of the psychotropic medications. The LPN stated he was unsure as to why the psychotropic medications were not care planned.</p> <p>3. Review of the clinical records revealed Resident #6 was admitted 04/01/10 with diagnoses which included Left Knee Repair, and Seizure Disorder.</p> <p>Review of the facility's Side Rail Assessment dated 04/01/10 revealed bilateral half side rails were to be used for Resident #6, however the assessment was not completed to indicate the reason for using the side rails. In addition, review of the facility's Initial Care Plan revealed the facility failed to implement any goals or interventions related to the use of side rails.</p> <p>Observations on 04/06/10 at 10:50 AM revealed Resident #6 lying in bed with bilateral side rails in the up position. Continued observations on 04/07/10 at 8:44 AM and 11:10 AM revealed the resident lying in bed with bilateral side rails in up position.</p> <p>Interview on 04/08/10 at 12:10 PM with Licensed Practical Nurse (LPN) #2, who was the resource nurse on the day of the interview, revealed it was</p>	F 281	<p>F281 483.20 (k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>1. One resident could have been affected by this deficiency however the order was clarified with ARNP and lab order was cancelled.</p> <p>2. A review all other residents physician orders was conducted by Director of Nursing and Resource Nurse and no residents were affected by this deficiency.</p> <p>3. A review of the policy entitled "Transcribing Orders" (Exhibit 9) by the Director of Nursing, and Administrator, indicated no need for policy revision. An in-service (Exhibit 10) by Director of Nursing for all licensed staff regarding proper transcription of orders, order clarification and notification of MD was conducted on 5/6/10.</p> <p>4. Chart check to be done on each shift by primary nurse to ensure orders have been properly transcribed and clarified if necessary. Director of Nursing or designee will do chart checks on all patients to ensure proper order transcription weekly x three months then monthly for six months. Quarterly reports made to the QI committee for any additional follow up.</p>	

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F 281	<p>Continued From page 7</p> <p>the policy of the facility to complete an assessment for all residents related to the use of side rails upon admission. In addition, the interview further revealed a Care Plan should have been developed for the use of side rails.</p> <p>The facility was unable to provide evidence an assessment or Care Plan related to the use of side rails had been completed for Resident #6.</p> <p>In addition, review of the Admission Order Sheet, dated 04/01/10, revealed a Physician's Order for a daily PT/INR to be obtained. The facility was unable to provide evidence this lab had been drawn as ordered.</p> <p>Interview on 04/07/10 at 11:40 AM with Licensed Practical Nurse (LPN) #4 revealed the facility does not draw PT/INRs on residents who receive Lovenox. She stated Resident #6 was ordered Lovenox, which does not require a PT/INR. The LPN indicated the nurse who took off the admission orders for the resident's Lovenox should have clarified with the physician that Lovenox did not require an order for a PT/INR and discontinued the order for the PT/INR.</p> <p>The facility was unable to provide evidence the order for the PT/INR had been discontinued or clarified with the Physician.</p> <p>4. Review of the clinical records revealed Resident #7 was admitted to the facility 04/03/10 with diagnoses which included Right Knee Replacement.</p> <p>Review of the facility's Side Rail Assessment dated 04/03/10 revealed bilateral half side rails were to be used for Resident #7 related to</p>	F 281		

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F 281	<p>Continued From page 8 mobility and independence.</p> <p>Review of the Initial/Immediate Need Care Plan revealed the facility failed to implement goals and/or interventions related to this resident's use of side rails.</p> <p>Observation on 04/07/10 at 3:25 PM revealed bilateral side rails were in the up position on the bed, while Resident #7 was in bed.</p> <p>Interview on 04/08/10 at 12:10 PM with Licensed Practical Nurse (LPN) #2, who was the resource nurse on the day of the interview, revealed he was unable to provide evidence a Care Plan had been developed related to the use of side rails for Resident #7. He indicated the use of side rails should have been noted on Resident #7's Care Plan.</p> <p>5. Review of the clinical records revealed Resident #4 was admitted to the facility on 03/29/10 with diagnoses which included a Recent Lumbar Kyphoplasty.</p> <p>Review of the Side Rail Assessment, dated 03/29/10, revealed the facility recommended bilateral side rails to be utilized for Resident #4 to promote independence and mobility.</p> <p>Observations on 04/06/10 at 11:00 PM and on 04/07/10 at 8:50 AM revealed Resident #4 lying in bed with bilateral side rails in up position.</p> <p>Review of the Initial Care Plan, dated 03/29/10, revealed no documented evidence the facility care planned the resident's use of the side rails.</p> <p>Interview on 04/08/10 at 12:10 PM with LPN #2</p>	F 281			

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F 281	Continued From page 9 revealed she was assigned to the unit where Resident #4 resided. She indicated if a resident had side rails, then a Care Plan should include the use of the side rails.	F 281		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</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 and interview it was determined the facility failed to prepare, distribute and serve food under sanitary conditions. Observations revealed baking trays were stored wet on two (2) different occasions. In addition, staff failed to provide handwashing hygiene during the evening meal while serving trays after resident contact.</p> <p>The findings include:</p> <p>Observations on 04/08/10 at 9:10 AM and on 04/07/10 at 11:03 AM revealed six (6) stainless steel baking trays were stored stacked and wet on a storage shelf.</p> <p>Interview on 04/08/10 at 9:10 AM and 04/07/10 at 11:03 AM with the Dietary Manager (DM) revealed the stainless steel baking trays were to</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <ol style="list-style-type: none"> <li>1. No residents were known to be affected by this deficiency.</li> <li>2. All residents could have potentially been affected but through monitoring by Resource nurses and primary care nurses for signs of symptoms of gastrointestinal problems no affects or trends were identified .</li> <li>3. Immediate removal of pots and pans by Food Service Manger, Larry Little. All pots and pans were rewashed, sanitized and air dried by porters in the dietary department according to policy and procedure #NS 317 "Hazard Management and Prevention/dishes and Silverware" (Exhibit 11). An in-service (Exhibit 12) conducted by Larry Little, Food Service Manger to all porters and management on policy was given on 4/7/10 and 4/8/10.</li> <li>4. Managers on duty will check the pot/pan area daily to ensure pots and pans are air dried and stored according to policy. Larry Little, Food Service Manger or designee to monitor weekly to ensure proper procedure for pots/pans washed, sanitized and dried according to policy. Cardinal Hill Dietary Consultants will inspect area monthly for six months and report findings to Department Manager and the facilty Administrator. Any problems identified will be corrected</li> </ol>	5/1/10

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508		
(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)	(X6) COMPLETION DATE	
F 371	<p>Continued From page 10</p> <p>be air dried prior to being placed on the storage rack. He stated dietary staff were aware of the air drying process and was unsure why staff failed to use the drying rack prior to placing the baking trays on the storage shelf.</p> <p>Review of the facility policy entitled "Washing Pots and Pans" dated 04/2006 revealed all items would be air dried and pans should never be stacked wet on the storage shelves.</p> <p>Observations during the evening meal on 04/08/10 at 5:20 PM revealed Certified Nursing Assistant (CNA) #7 set up and served a tray to a resident. The CNA failed to perform hand hygiene and continued to serve another resident's tray which include raising the resident's bed and performing tray set up. The CNA then retrieved another tray from the hall tray cart and set up the tray in another resident's room. The CNA was observed to serve the resident's tray without performing hand hygiene. Hand sanitizing was not observed by CNA #7 until after having contact with three (3) different residents.</p> <p>Interview on 04/08/10 at 5:35 PM with CNA #7 revealed the facility's policy was to sanitize or wash hands between each resident contact. CNA #7 revealed "I did realize I forgot to sanitize". He further stated, "It is important to help patients stay healthy."</p> <p>Interview on 04/08/10 11:15 AM with Registered Nurse (RN) #3, who was the acting resource nurse for the day, revealed it was the facility's policy that staff serving trays room to room should sanitize their hands before pulling out the next tray, so on leaving the resident's room they should sanitize their hands, to prevent the spread</p>	F 371	<p>will be reported to the QI committee on a quarterly basis for any further action necessary.</p> <p>F 371 483.35 (I) FOOD PROCEDURE STORE/PREPARE/SERVE-SANITARY</p> <p>1. Resident #7 could have potentially been affected by this deficiency however this resident was monitored closely by primary nurses and no adverse affects were noted.</p> <p>2. No residents were identified to be affected by this deficiency and immediately all staff where reminded of proper hand-washing and sanitizing techniques by Resource nurse and Administrator.</p> <p>3. A review of policy/procedure entitled, "Hand washing" by Director of Nursing, Teresa LeMaster, indicated no need for any policy/procedure revisions. (Exhibit 13). An In-service (Exhibit 14) was given to all staff members on 4/23/10 and 4/30/10 by Kim McHatton CRRN, Infection Preventionist. The in-service discussed the policy and procedure and each staff member was required to demonstrate proper hand washing technique and proper use of hand sanitizing technique.</p> <p>4. DON, Teresa LeMaster or designee, will have weekly spot checks on all three shifts (Exhibit 15) weekly for two months, monthly x nine months to ensure proper hand washing techniques are being followed by staff. Any problems identified will be corrected immediately and a report to the QI committee will be given quarterly for action to be taken when procedures not followed.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185460	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 of infection.  Review of the facility policy entitled "Handwashing" undated, revealed the staff would provide proper hand washing techniques before and after providing resident care.	F 371		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185460</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - 7TH FLOOR LTC UNIT</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/06/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 SOUTH LIMESTONE ST LEXINGTON, KY 40508</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 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was initiated and concluded on April 6, 2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility was in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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