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

RECEIVED NOV - 3 2011 Division of Health Care Southern Enforcement Branch

PRINTED: 10/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185173		10/06/2011

NAME OF PROVIDER OR SUPPLIER: SUNRISE MANOR NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 200 NORTH FLEET DRIVE, SOMERSET, KY 42501

(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 000	INITIAL COMMENTS A standard health survey was conducted on 10/04-06/11. Deficient practice was identified with the highest scope and severity being at "F" level.	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 policies, the facility failed to ensure a resident having pressure sores received the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one of eighteen sampled residents (Resident #7). Observation of a skin assessment on 10/05/11, revealed Resident #7 had two open areas to the buttocks that had not been reported by the State Registered Nurse Aide. The findings include: A review of the facility's policy titled Pressure Ulcer Prevention/Treatment (dated April 2009) revealed all residents' skin would be assessed	F 314	F314 One resident, ~~R1~~ R7, was affected by this practice. Upon discovery the charge nurse immediately contacted the physician and got an order for a treatment to the buttocks. That area has been healed and now has just a preventative skin treatment. The ADM, DON,UM(Unit Managers),ETD,CRC(Clinical Reimbursement Coordinator) and RDCS(Regional Director of Clinical Services) did a facility-wide 100% skin audit on 10/6/11 to identify any skin change. Any issues identified was immediately reported to the physician and family.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gill Spurgeon | TITLE: Admin. | (X8) DATE: 10/28/11

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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F 314	Continued From page 1 . . . weekly using the Braden Risk Assessment and Skin Integrity Assessment: Prevention and Treatment Plan of Care. Continued review of the policy revealed a resident with pressure ulcers would receive necessary treatment and services to promote healing and prevent infection. A review of the medical record revealed the facility admitted Resident #7 on 04/02/07. Resident #7's current diagnoses include Alzheimer's disease, Muscle Weakness, and Dysphagia with Gastrostomy Tube Placement. A review of the Annual Minimum Data Set (MDS) assessment dated 08/15/11, revealed the facility assessed the resident to require total assistance with bed mobility, toileting, and personal hygiene. Observation of a skin assessment performed by CNA #1, CNA #3, and the Director of Nursing (DON) on 10/05/11, at 2:20 PM, revealed Resident #7 had one open area to the left buttock measuring 2 centimeters (cm) by 1.2 cm, and one open area to the right buttock measuring 3 cm by 0.5 cm, which had been unidentified by the facility staff. Interview with CNA #1 on 10/05/11, at 2:25 PM, revealed during her morning rounds (she was unable to recall the exact time) she had noticed the two open areas to Resident #7's buttocks but had not reported them to anyone. Further interview with CNA #1 revealed that she should have reported any change in a resident's skin to the charge nurse. Interview with CNA #4 on 10/05/11, at 3:45 PM, revealed he had been assigned to provide care to Resident #7 on the 3 PM-11 PM shift the previous	F 314	A re education was initiated by the ETD on 10/6 and completed on 10/15/11. for all nursing staff. We reviewed the policies on reporting skin issues , with emphasis on immediate and timely reporting skin changes to the charge nurse. Weekly skin assessments are being audited by the Treatment Nurse and 10 random skin audits to be completed weekly x 4 weeks beginning week of 10/21/2011.Any issues identified will require one on one education by the ETD. DON, UM, and Department Managers to complete turning and repositioning audits on all shifts randomly 4 weeks beginning week of 10/21/2011 . Then we will monitor this for 2X a week for 2 weeks and then we will monitor skin and positioning on all shifts 1X weekly for 2 weeks to ensure that all residents skin is intact and they are positioned appropriately while in bed. Every two hour rounds continue to be performed by all charge nurses daily. The facility QA Committee will review results of these audits at our regularly scheduled monthly meetings. We will make recommendation at that time. Date of Compliance: 11/1/11	

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F 314	Continued From page 2 evening on 10/04/11, and stated the resident had not had any open areas identified on the buttocks at that time. An interview with Licensed Practical Nurse (LPN) # 3 on 10/05/11, at 4:05 PM, revealed she was not aware of the two Stage II open areas to Resident #7's buttock prior to the observation of the skin assessment performed on 10/05/11, at 2:20 PM. An interview with the Director of Nursing (DON) on 10/05/11, at 4:30 PM, revealed CNAs are trained to notify the nurse with any change in a resident's skin. Further interview revealed CNA #1 should have immediately reported the two Stage II pressure ulcers to the charge nurse.	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store, prepare, and distribute foods under sanitary conditions. During observation of the evening tray assembly line on 10/04/11, at 5:30 PM, the Dietary Department cook was	F 371	F371 No resident was identified. All residents have the potential to be affected. All the sinks in the kitchen were immediately assessed to identify proper functioning by the DSM(Dietary Service Manager). The hand washing sink was unclogged, as was the three compartment sink, as soon as we were made aware by a licensed plumber. Both sinks were functioning properly on 10/4/11 before the kitchen had closed for the evening, approximately 8:00pm. The cook was reminded by the DSM to check the temperature and she did so after the first few trays.	

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NAME OF PROVIDER OR SUPPLIER: SUNRISE MANOR NURSING AND REHABILITATION CENTER

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F 371	Continued From page 3 observed to handle her personal glasses and placed the glasses on her face. The Dietary Department cook continued to serve foods without changing the soiled gloves used to handle the glasses. The Dietary Department hand sink and three-compartment sink were clogged and not emptying properly. The findings include: A review of the Facility Cooking Policy and procedure (dated July 2008/2010) revealed the dietary staff was to wash their hands often and as needed. The policy also indicated staff was to record the food temperatures in the Food Temperature Log prior to serving the residents. A review of the hand Hygiene Policy and Procedure (dated 2006/2010) revealed the staff was to use hand hygiene to remove dirt, organic material, and transient organisms. 1. Observation of the tray line assembly was conducted on 10/04/11, at 5:30 PM. The Dietary Department cook assembling trays was observed to pick up her glasses with gloved hands and placed the glasses on her face. The dietary cook was observed to continue to serve the foods without changing her gloves and washing her hands. An interview was conducted with the dietary cook at 5:35 PM on 10/04/11. The dietary cook stated she forgot to wash her hands and change her soiled gloves. 2. Further observations of the kitchen food preparation area at 5:40 PM on 10/04/11, revealed the three-compartment sink was	F 371	A re education was completed with all dietary staff by the DSM on 10/6/11. The policy regarding taking temps, hand washing, and reporting any sink problems to maintenance were all covered. The Dietary Manager will monitor temps, as well as hand washing at least three time a week for two weeks beginning week of 10/23/2011, then weekly for two weeks, and then at least monthly to ensure it is done properly and timely. The Facility Quality Assurance Committee, composed of the Adm.(Administrator), DON(Director of Nursing), DSM, ETD(Education Training Director)LED(Life Enrichment Director) and Maintenance Supervisor, will review the results of the hand washing and temperature audits at their next regular monthly meetings on10/29/11 and 11/18/11, and make recommendations as needed. At that time it will be determined to continue the audits if necessary. Date of Compliance: 11/1/11	

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F 371	Continued From page 4 clogged and contained dirty, greasy water in all three compartments. An interview conducted with the Dietary Manager on 10/06/11, revealed the sink had stopped up prior to the supper meal on 10/04/11. A second interview conducted with the Maintenance staff on 10/06/11, at 2:30 PM, revealed that he had not been notified of the nonfunctioning sink until 5:45 PM on 10/04/11. 3. Observation of the hand sink on 10/04/11, at 5:30 PM, which is required by the Kentucky Retail Food Code to be available in a food preparation area, was observed to be clogged and filled with soiled tan slimy water. An interview conducted with the Dietary Manager revealed the sink had become clogged prior to the supper meal on 10/04/11. A second interview conducted with the Maintenance staff on 10/06/11, at 2:30 PM, revealed he had not been notified of the nonfunctioning sink until 5:45 PM on 10/04/11. An interview was conducted with the Facility Administrator on 10/06/11, at 12:00 PM. The Facility Administrator stated she had not been told the hand sink and three-compartment sink had become clogged. 4. During observation of the tray line assembly on 10/04/11, at 5:30 PM, six trays were distributed to residents without checking temperatures prior to service.	F 371		

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F 371	Continued From page 5 An interview was conducted with the Dietary Manager on 10/06/11, at 12:30 PM. The Dietary Manager stated that he/she was unaware the food temperatures had not been checked prior to distribution of the resident trays.	F 371		

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	185173	A. BUILDING 01 - BUILDING B. WING _____	10/04/2011

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type II (000) SMOKE COMPARTMENTS: Eight COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II natural gas generator A life safety code survey was initiated and concluded on 10/04 /11, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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