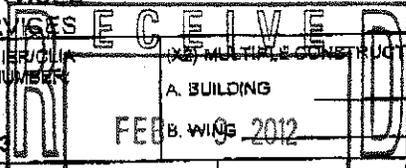


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FORM APPROVED
OMB NO. 0938-0391

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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ 2012	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4440 US HWY 411 SOUTH, P O BOX 618 HYDEN, OH 41749
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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 000	INITIAL COMMENTS	F 000		
F 226 SS=0	<p>A standard health survey was conducted on 01/03-06/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure policies and procedures established to prohibit mistreatment/abuse of residents had been implemented. A review of employee files revealed the facility failed to conduct required background screenings for two of five sampled employees (Employee #4 and Certified Nursing Assistant #5).</p> <p>The findings include: A review of the facility's Abuse policy (no date noted) revealed a criminal background check would be completed on new employees within two working days from the date of hire. Further review of facility policy revealed the facility was also to verify a potential employee's status on the Nurse Aide Abuse Registry with the Kentucky Board of Nursing (KBN) prior to employment. A review of personnel files revealed the facility had hired Employee #4 on 09/08/11, to perform</p>	F 226	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa B. Sparks</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-31-12</i>
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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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F 226	Continued From page 1 duties in the Dietary Department. However, based on documentation, the facility failed to conduct a criminal background check for the employee. In addition, based on documentation, the facility failed to verify Employee #4's status with the KBN Nurse Aide Abuse Registry prior to employment. A review of the personnel file for Certified Nursing Assistant (CNA) #5 revealed the facility hired the employee on 09/20/11. Further review of the personnel file revealed no evidence the facility had conducted a criminal background check or verified Employee #5's status with the KBN Abuse Registry prior to employment. An interview conducted on 01/06/12, at 12:15 PM, with the Director of Nursing (DON) revealed a criminal background check and verification of an employee's status with the KBN Abuse Registry were required to be performed on all new employees at the time they were hired. Continued interview with the DON revealed the facility could not provide evidence that the required background screenings had been completed for Employee #4 or CNA #5.	F 226		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	<i>See Attached</i>	

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F 246	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record review it was determined the facility failed to ensure the reasonable needs and preferences for residents who had paid for cable/satellite television were met. Interview and observations throughout the facility revealed the cable/satellite television reception was of poor quality and made it impossible/difficult for residents to view the lower six stations on the televisions.</p> <p>The findings include:</p> <p>Interview with the Administrator on 01/05/12, at 2:30 PM, revealed there was not a policy related to cable/satellite television.</p> <p>Observations conducted on 01/03/12 through 01/05/12 throughout the facility revealed the lower six channels on the cable/satellite system had poor reception. The reception was so poor the residents could not view the television programs. Further observations and interviews revealed many of the other channels "came in and went out" occasionally during the day.</p> <p>Interviews with Resident #8 on 01/04/12, at 9:00 AM, Resident A on 01/05/12, at 9:30 AM, and the group interview on 01/05/12, at 3:30 PM, revealed residents who paid for cable/satellite television were unable to watch television programs due to poor reception. The residents stated the Activities Director was aware of the situation and the Resident Council had reported the poor reception during a meeting.</p> <p>Review of the Resident Council meeting minutes</p>	F 246	Attached	

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F 246	Continued From page 3 revealed the poor reception was addressed in a Resident Council meeting in October 2011. Based on documentation, the Activity Director had contacted the television satellite company on 10/03/11, and repairs were made in October 2011. An interview with the Activities Director (AD) on 01/04/12, at 3:30 PM, revealed the facility switched from cable television to a satellite system in 2009. However, the AD stated the lower television channels had become unavailable approximately two months earlier, the satellite company was contacted, and the company sent a repairman to the facility on 01/05/12. The AD stated the repairman had determined the satellite needed to be repaired and the satellite company obtained a replacement part. However, according to the AD, the satellite company had not sent a repairman back to the facility to install the replacement part. The AD stated each resident paid ten dollars a month for the cable/satellite service and acknowledged the satellite company should have been contacted to make the needed repairs prior to 01/05/12.	F 246		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the temperature of the facility was	F 257	<i>See Attached</i>	

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F 257	<p>Continued From page 4</p> <p>maintained at a temperature range of 71-81 degrees Fahrenheit as required. Observation of resident activities conducted in the facility's main dining room on 01/04/12, at 10:00 AM, revealed the temperature of the room was 63 degrees Fahrenheit.</p> <p>The findings include:</p> <p>Interview with the Administrator on 01/05/12, at 2:30 PM, revealed the facility did not have a policy related to room temperatures in the facility.</p> <p>Observation of the morning activity in the main dining room on 01/04/12, revealed 15 residents sitting around tables eating doughnuts and drinking coffee with the Activities Director and the Dietary Manager. Facility staff was observed to enter and exit the exterior door of the dining room to go outside for smoke breaks and each time the exterior door was opened cold air from the outside flowed into the dining room. The dining room temperature was obtained and revealed the temperature of the room was 63 degrees Fahrenheit.</p> <p>The Maintenance Director was notified of the temperature in the main dining room on 01/04/12, at 10:30 AM. The Maintenance Director adjusted the heat in the dining room and obtained the temperature of the room by means of a digital thermometer. However, the temperature of the room only reached 68 degrees Fahrenheit.</p> <p>Interview with the Maintenance Director on 01/04/12, at 10:30 AM, revealed the temperature of the dining room should be maintained at "around" 72 degrees Fahrenheit. The</p>	F 257	Attached		

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F 267	Continued From page 5 Maintenance Director stated the temperature of the dining room dropped when staff frequently opened/closed the exterior door to the dining room. The Maintenance Director stated the room temperature was not part of the regular monitoring performed by the Maintenance Director.	F 257	
F 281 SS=D	483.20(k)(3)(i) 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, record review, and review of facility policy the facility failed to ensure physician's orders were implemented for one of eighteen sampled residents (Resident #4). A review of physician's orders for Resident #4, dated 11/09/11 revealed the physician had requested staff to increase a bolus of water administered to Resident #4 by means of a gastrostomy tube to 350 cubic centimeters every six hours. However, a review of the Medication Administration Record revealed staff had failed to administer the water in accordance with physician's orders for Resident #4. The findings include: A review of the facility's policy entitled Physician's Orders (not dated) revealed physician's orders would be noted and transcribed to the appropriate place on the resident's Medication Administration Record (MAR).	F 281	<i>See Attached</i>

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F 281	<p>Continued From page 6</p> <p>A review of the medical record for Resident #4 revealed the facility admitted the resident on 08/05/08, with diagnoses of Alzheimer's, Hypertension, and Gastrostomy tube placement. Further review of the medical record revealed facility staff had completed a Significant Change Minimum Data Set (MDS) Assessment on 10/03/11, and noted Resident #4 required total assistance with bed mobility and eating.</p> <p>Continued review of Resident #4's physician's orders dated 11/09/11, revealed the physician had requested staff to increase the amount of water administered by bolus through the resident's gastrostomy tube to 350 cubic centimeters (cc) every six hours.</p> <p>A review of Resident #4's MAR for 11/09/11 through 11/30/11, revealed the physician's orders dated 11/09/11, had not been transcribed onto the resident's MAR. Further review of the residents MARs revealed facility staff had documented that the amount of fluid (water) given to Resident #4 was 300 cc every six hours through the gastrostomy tube for the months of December 2011 and January 2012 instead of 350 cc of water prescribed by the physician on 11/09/11.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 01/05/12, at 11:15 AM, revealed the amount of fluids to be administered to residents through gastrostomy tubes would be documented on the MAR and should be in compliance with current physician's orders.</p> <p>An interview with the Director of Nursing (DON) on 01/06/12, at 12:15 PM, revealed Nursing staff</p>	F 281	Attached		

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F 281	Continued From page 7 was to transcribe the physician's orders onto the appropriate administration record at the time the order was received. Further interview with the DON confirmed Resident #4's MARs for November, December, and January showed evidence that facility staff had failed to administer water boluses as ordered by the physician.	F 281	<i>See Attached</i>	
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 review of facility policy it was determined the facility failed to ensure residents with pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one of eighteen sampled residents (Resident #4). The facility had assessed Resident #4 to have a Stage IV pressure sore to the coccyx and had developed interventions on the resident's care plan to turn and reposition the resident from side to side every hour. Although observations conducted on 01/04/12, revealed the resident was sitting up in a geri-chair from 8:55 AM until 12:30 PM, a review of the established plan of care revealed facility	F 314		

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F 314	<p>Continued From page 8</p> <p>staff failed to develop interventions related to repositioning the resident when in the chair and to the timeframe the resident was to sit in the chair in an effort to promote healing of the resident's pressure sore and/or to prevent new sores from developing.</p> <p>The findings include:</p> <p>A review of the facility policy entitled Skin Ulcers (not dated) revealed the Interdisciplinary Team would develop individualized treatment plans for the prevention of skin breakdown and/or treatment of any existing pressure areas.</p> <p>A review of the Comprehensive Care Plan Policy (not dated) revealed the facility had failed to address how individualized care plan interventions were to be implemented by facility staff.</p> <p>A review of the medical record for Resident #4 revealed the facility admitted the resident on 09/05/08, with diagnoses of Alzheimer's, Hypertension, and Anemia. A review of a Significant Change Minimum Data Set (MDS) assessment dated 10/03/11 revealed the facility had assessed the resident to be severely impaired with daily decision-making and to require total assistance with bed mobility, transfers, toilet use, and bathing.</p> <p>A review of Resident #4's care plan, which had been updated on 11/28/11, revealed the facility assessed the resident to have alterations in skin integrity. Documentation on the care plan revealed the resident had a Stage IV pressure ulcer to the coccyx. Further review of Resident</p>	F 314	Attached	

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F 314	<p>Continued From page 9</p> <p>#4's care plan revealed staff was to turn and reposition the resident every hour from side to side, and to avoid activity which may result in skin breaks. However, the care plan failed to provide facility staff with interventions to promote healing of the resident's pressure sore and/or to prevent the development of new pressure sores when the resident was assisted to sit in a geri-chair.</p> <p>Observations conducted on 01/04/12, at 9:55 AM, revealed Resident #4 was sitting in a geri-chair. Additional observations conducted on 01/04/12, at 10:00 AM, 11:05 AM, 12:00 PM, and 12:30 PM, revealed the resident continued to sit in the geri-chair.</p> <p>Interview with Certified Nursing Assistant (CNA) #6 on 01/04/12, at 12:20 PM, revealed she was assigned to care for Resident #4 during the 6:00 AM to 2:30 PM shift on 01/04/12. Further interview with CNA #5 revealed she transferred Resident #4 into the geri-chair at 8:00 AM on 01/04/12, and the resident remained in the geri-chair from 6:00 AM through the time of the observation of the resident at 12:30 PM on 01/04/12.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 01/04/12, at 12:30 PM, revealed she was assigned to provide nursing care to Resident #3 from 7:00 AM to 7:00 PM on 01/04/12. LPN #3 stated she conducted "rounds" on her assigned residents to ensure care plan interventions in place had been implemented. Continued interview with LPN #3 related to the implementation of Resident #4's care plan interventions revealed she had not "had time to</p>	F 314	Attached		

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F 314	<p>Continued From page 10</p> <p>pay attention" to how the residents had been turned and repositioned "today." Interview with LPN #3 revealed in the nurse's opinion Resident #4 appeared to be "sitting on (his/her) butt" while in the geri-chair and indicated the resident had not been positioned on his/her side in an effort to relieve pressure from the resident's pressure area.</p> <p>Interview with LPN #4, Clinical Coordinator, on 01/06/12, at 12:00 PM, revealed the facility had developed a plan of care for Resident #4 to be turned from side to side only in an effort to relieve pressure and to promote healing of the pressure area on the resident's coccyx. LPN #4 confirmed the facility had failed to develop interventions related to repositioning and/or the frequency of repositioning Resident #4 when the resident was sitting in the geri-chair in an effort to relieve pressure from the Stage IV pressure area. In addition, LPN #4 stated an intervention had not been established on the care plan to direct staff on the length of time the resident was to sit in the geri-chair. According to LPN #4, Resident #4 should not have been allowed to sit up in a geri-chair from 6:00 AM to 12:30 PM, due to the resident's risk for the development of pressure sores and/or to promote healing of the resident's pressure sore and/or to prevent the development of new pressure sores.</p> <p>Interview with the Director of Nursing (DON) on 01/04/12, at 3:50 PM, revealed facility staff had developed care plan interventions for Resident #4 related to the Stage IV pressure sore to his/her coccyx. However, the DON confirmed there were no interventions related to the resident's use of the geri-chair, how staff was to reposition the</p>	F 314	<p><i>Attached</i></p>	
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F 314	Continued From page 11 resident in the chair, or the timeframe the resident was to sit in the chair. Further interview with the DON confirmed staff should not have allowed Resident #4 to sit in a geri-chair from 6:00 AM to 12:30 PM.	F 314	<i>See Attached</i>	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 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 ensure one of eleven residents identified to be incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #5 was observed to be incontinent of urine on 01/05/12, at 10:10 AM, when staff was checking the resident for incontinence and turning/repositioning the resident. Facility staff failed to observe if the resident's incontinence brief was wet and failed to provide incontinence care for Resident #5. The findings include:	F 315		

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F 315	<p>Continued From page 12</p> <p>A review of the facility policy entitled Bowel and Bladder Training (undated) revealed Incontinent residents were required to be checked and changed every two hours or as specified on the plan of care.</p> <p>A review of the medical record for Resident #5 revealed the facility had admitted the resident on 11/16/11, with diagnoses that included Listeria Meningitis, Status Post Suboccipital Decompression, and an unstageable pressure area to the coccyx.</p> <p>A review of the admission Minimum Data Set (MDS) assessment dated 11/28/11, revealed Resident #5 required total assistance of two staff persons for transfers and was incontinent of bowel and bladder.</p> <p>A review of the Plan of Care developed for Resident #5 revealed staff was to turn and reposition the resident every hour, check and/or change the resident for Incontinence episodes every two hours, and anticipate the resident's needs to keep the resident clean, dry, and comfortable. Further review of the plan of care revealed peri-care was to be provided as needed.</p> <p>State Registered Nurse Aide (SRNA) #3 and SRNA #4 were observed on 01/05/12, at 10:10 AM, to turn and reposition Resident #5. Resident #5 was observed to be incontinent of urine, however, SRNAs #3 and #4 did not provide incontinence care to the resident.</p> <p>Interviews conducted with SRNAs #3 and #4 on 01/05/12, at 10:15 AM, revealed Resident #5 had been checked and changed earlier. However, the</p>	F 315	Attached		

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F 315	Continued From page 13 SRNAs stated they had not noticed the resident had an incontinence episode of urine and, as a result, had left the resident wet. SRNA #3 and SRNA #4 acknowledged incontinence care should have been provided to the resident. An interview conducted with the Unit Manager (UM) on 01/06/12, at 12:05 PM, revealed the UM monitored resident care on a daily basis and conducted "spot checks" one to two times a week to ensure incontinence care was provided appropriately to residents. Further interview revealed the UM had not identified any concerns related to the provision of resident care by SRNAs #2 and #3.	F 315		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide one of eighteen sampled residents with sufficient fluid intake to maintain proper hydration and health (Resident #4). Review of dietary recommendations for Resident #4 dated 11/09/11, revealed the Registered Dietitian had recommended an increase in water flushes through the gastrostomy tube related to abnormal laboratory results. A review of the Medication Administration Record for Resident #4 revealed facility staff was not administering the water flushes as recommended by the Registered Dietitian (refer to F281).	F 327	<i>See Attached</i>	

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F 327	<p>Continued From page 14</p> <p>The findings include:</p> <p>A review of the facility policy titled Policy Regarding Notification of Change in Condition To Registered Dietician (not dated) revealed the facility staff was required to notify the Registered Dietitian when a resident's status indicated a need for a nutritional evaluation. Further review of the policy revealed when the Registered Dietitian's evaluations and recommendations were received the resident's physician would be notified and physician's orders written if indicated.</p> <p>Review of the medical record for Resident #4 revealed the facility admitted Resident #4 on 09/05/08, with diagnoses of Alzheimer's, Anemia, Malnutrition, and Gastrostomy Tube Placement. Further review of the medical record revealed a Significant Change Minimum Data Set (MDS) Assessment dated 10/03/11. Review of the MDS revealed the facility had assessed the resident to require total assistance with bed mobility, dressing, and eating.</p> <p>A review of the dietary recommendations dated 11/09/11, revealed the dietitian had recommended an increase in water flushes to 350 cubic centimeters (cc) to be administered per the resident's gastrostomy tube every six hours related to abnormal laboratory results.</p> <p>A review of the physician's orders for Resident #4 revealed on 11/09/11, the resident's physician was contacted, and the facility received an order to increase Resident #4's water flushes to 350 cc every six hours per the Registered Dietitian's recommendations. However, review of the</p>	F 327	<p><i>Attached</i></p>	

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F 327	<p>Continued From page 15</p> <p>Medication Administration Record for the month of 11/09/11, revealed no evidence that facility staff had transcribed the order onto the MAR. Further review of the resident's MARs for the months of November 2011, December 2011, and January 2012, revealed Resident #4 received 300 cc of water flush every six hours per gastrostomy tube, instead of the dietary recommended amount of 350 cc every six hours.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 01/04/12, at 11:15 AM, revealed staff nurses had been trained to administer water flushes per the resident's MAR. Further interview with LPN #2 confirmed Resident #4's MAR revealed facility staff had administered 300 cc water flushes every six hours.</p> <p>Interview with the Director of Nursing (DON) on 01/06/12, at 12:15 PM, revealed the nursing supervisors were responsible to check physician's orders and MARs for accuracy each month. Continued interview with the DON revealed she was unsure how the inaccurate transcription of physician's order to MAR continued and failed to be corrected from the month of November through January.</p>	F 327		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	F 441	<p><i>See Attached</i></p>	

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F 441	<p>Continued From page 16</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure staff washed their hands after each resident contact for which hand washing was indicated by accepted professional practice for one of eighteen sampled residents (Resident #1).</p>	F 441	Attached	

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F 441	<p>Continued From page 17</p> <p>A State Registered Nurse Assistant failed to wash/sanitize her hands and change gloves when indicated while providing incontinence care to Resident #1.</p> <p>The findings include:</p> <p>A review of the Infection Control Policy (undated) revealed "wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn."</p> <p>Observation of incontinence care on 01/04/12, at 9:00 AM, revealed State Registered Nurse Assistant (SRNA) #4 donned gloves and removed a soiled brief. The CNA went to the resident's dresser, opened the drawers, and obtained wipes without removing soiled gloves. The SRNA then proceeded to use peri-wipes on Resident #1, and apply a clean brief without changing gloves, washing hands, or donning clean gloves.</p> <p>Interview with SRNA #4 on 01/04/12, at 9:00 AM, revealed the SRNA knew she was required to change gloves after they were soiled and to wash her hands. SRNA #4 said the facility had provided training on when to change gloves and wash hands but she was nervous and "just forgot."</p> <p>Interview with LPN #1 and LPN #2 on 01/05/12, at 11:00 AM, revealed nurses made rounds to check on SRNAs and the duties that were performed. If a SRNA performed a duty incorrectly the SRNA was immediately stopped and re-educated on the correct procedure. The LPNs further stated an in-service was then conducted for all the SRNAs to assist with job</p>	F 441	<p><i>Attached</i></p>	
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F 441	Continued From page 18 performance.	F 441		
F 496 SS=D	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the</p>	F 496	See Attached	

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F 496	<p>Continued From page 19</p> <p>individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of employee records and interview it was determined the facility failed to ensure one of two Certified Nursing Assistants met competency requirements for a nurse aide. Review of employee files for Certified Nursing Assistant #3 on 01/06/12, revealed she was hired by the facility on 09/07/11. Further review of the employee record revealed at time of hire her Certified Nursing Assistant certification had lapsed.</p> <p>The findings include:</p> <p>A review of the facility policy titled Abuse Policy (not dated) revealed nursing assistants must have an active status on the Kentucky Board of Nursing (KBN) Registry, or proof of recent state approved training course if awaiting testing.</p> <p>A review of the employee file for Certified Nursing Assistant (CNA) #3 revealed a hire date of 09/07/11. Further review of the employee record revealed the facility had verified the CNA's status on the Abuse Registry, however, at the time of hire the CNA's nurse aide certification had lapsed.</p> <p>An interview with the Director of Nursing (DON) on 01/06/12, at 12:10 PM, revealed a CNA's</p>	F 496	<p><i>Attached</i></p>	

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F 496	Continued From page 20 certification status was to be verified at the time of hire. However, the DON was unaware that CNA #3's certification had lapsed, prior to the surveyor's review of the employee record.	F 496	<i>Attached</i>	

F 225

1. Criminal background checks were obtained for employee #4 and Certified Nursing Assistant # 5 on January 6, 2012. The status of employee #4 and Certified Nursing Assistant #5 was verified on January 6, 2102 with the KBN Nurse Aide Abuse Registry and were not on the abuse registry.
2. All employee files were reviewed to verify criminal background checks were obtained and that each employee file had been verified against the KBN Nurse Aide Abuse Registry.
3. In-Service was conducted by the Administrator with staff member responsible for personnel files on January 6, 2012. The designated staff member will obtain and maintain criminal background checks on all employees and will verify the status of each employee on the KBN Nurse Aide Abuse registry.
4. The Quality Assurance Committee designee will conduct an audit of newly hired employees to assure that criminal background checks are completed timely and filed appropriately. This audit will also include a review of all newly hired employees to verify that each have been checked on the KBN Nurse Aide Abuse Registry. All newly hired staff will be reviewed weekly to assure criminal background checks and KBN Nurse Aide Abuse Registry verifications have been completed. Weekly reviews will be completed for one month and then once per month for three months. Any discrepancies noted will be corrected immediately and reported to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

F 246

1. All residents receiving television service at the facility had clear reception restored on all channels on January 6, 2012. A technician had been contacted previously but had failed to resolve the problem and a technician did respond to facility on January 5th and restored clear reception service to all residents utilizing Bulk TV Services.
2. All residents receiving Bulk TV service at the facility had clear reception restored to all channels effective January 6, 2012.
3. The Activities Director / Director of Social Services, contacted technicians from Bulk TV to report ongoing problems with television reception. The AD/SS had previously reported poor reception service to the company and a technician made an initial visit but had not returned with needed parts to repair the issues. The technician arrived at facility on January 5, 2012 and made needed repairs to the service and examined the existing system to troubleshoot any other potential issues. Clear reception was restored to all channels on January 6, 2012. The technician stated that repairs were made to the system to circumvent the problem from recurring in the future.
4. The Quality Assurance Committee designee will monitor the television service to assure that all subscribed channels have clear reception. The designee will check the service on 5 televisions per week for one month and then 5 televisions monthly for three months. Any problems noted with reception or service will be corrected immediately and technicians notified if repair can not be made by facility staff. Any noted problems will be reported to the Quality Assurance Committee.
5. Date of Completion : February 1, 2012

F 257

1. Facility staff were instructed not to utilize the exit door to the outside in the dining room for access to the break area due to the extreme cold temperature outside but instead to use an alternate exit door. Maintenance adjusted the thermostat in the dining room to bring the temperature in the dining room to an acceptable level of between 71-81 degrees Fahrenheit.
2. Residents utilizing the dining room during this period for group activities, dining or individual recreation could have had the potential to have been affected. Staff were instructed to not utilize the dining room door exit to the outside to access the designated employee smoking area but instead to use an alternate door to access this area.
3. In-service was conducted on January 6, 2012 for all staff by Director of Nursing. Staff were informed that if the outside temperature is 40 degrees or below to utilize the employee entrance / exit door to access the designated employee smoking area.
4. The Quality Assurance Committee designee will check the temperature of the dining room to assure that an appropriate temperature is maintained by 71-81 degrees Fahrenheit. The dining room will be checked 5 times a week for one month and then 5 times a month for three months. Any temperature note that is not at 71-81 degrees Fahrenheit will be corrected immediately and reported to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

F 281

1. Resident #4 is receiving water bolus of 350cc every six hours as ordered the by the physician. The order was clarified and transcribed onto the resident # 4's MAR in accordance with facility policy.
2. Nursing Administrative Nurses reviewed all the resident's records who are receiving water bolus to assure accuracy of physician's orders compared to the MAR and verified the amount of water bolus that each resident is receiving per gastrostomy tube.
3. An In-service was conducted on January 5, 2012 by Clinical Coordinators with licensed nursing staff regarding verifying physicians' orders for water bolus against the MAR for each resident. The in-service also included review of the facility policy and procedure for transcribing to the MAR when a physician order is received.
4. The Quality Assurance Committee designee will review the resident records to assure that water boluses are administered in accordance with current physician orders and are transcribed accurately to the MAR of each resident. A total of 5 records will be reviewed weekly for one month and then 5 records reviewed monthly for three months. Any irregularity will be corrected immediately and reported to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

F 314

1. Resident #4 is being turned and repositioned on an hourly schedule from side to side only and is only out of bed, sitting in a Geri-chair for no more than one hour at a time.
2. Any resident who is assessed to be turned and repositioned per facility staff will have interventions on the care plan that will direct staff on the frequency and length of time that turning and repositioning is to be done. Any resident needing turning and repositioning that is assisted to a Geri-chair for sitting will have clear interventions in place on their individualized care plan that indicate the frequency, position, and length of time that the resident is to be in sitting position while in Geri-chair.
3. In-service training was conducted on January 4, 2012 by the Director of Nursing along with Administrative Nursing staff with the nursing department. Education included promoting healing of pressure sores and the prevention of pressure sores; turning and repositioning; and appropriate interventions for staff that are clearly defined on the plan of care including frequency and length of time for turning and repositioning as well as interventions related to a resident who may be sitting up in a chair.
4. The Quality Assurance Committee designee will audit all residents assessed to require turning and repositioning care by facility staff to assure that no new areas develop and that any existing pressure ulcers receive treatment to promote healing. The audit will verify that interventions are clearly addressed on the care plan for staff to utilize including length and frequency. The audit will include 5 charts to be reviewed per week for one month and then 5 charts per month for three months. Any irregularity will be corrected immediately and referred to the Quality Assurance Committee for further review.
5. Date of Completion: February 1, 2012

F 315

1. Resident #5 received incontinence care by SNRA #3 and SNRA #4.
2. Residents who are Incontinent are being checked and changed every two hours, as needed, or as specified by their individual plan of care.
3. In-service education on incontinence care and services with nursing staff was conducted on January 6, 2012 by Clinical Coordinator. Education included the need to check for the need for incontinence care and providing it during regular rounds and as needed.
4. The Quality Assurance Committee designee will review incontinence care and services are provided to incontinent residents on various shifts. The review will include checking on 5 incontinent residents per week on various shifts for one month and then 5 incontinent residents per month for three months on various shifts. Any irregularities will be corrected immediately and referred to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

F 327

1. The physician of resident #4 was notified and the order for water bolus was clarified and correctly transcribed to the MAR. Resident #4 is receiving 350 cc of water bolus every six hours per gastrostomy tube.
2. Nursing Administration reviewed all residents receiving water flushes to assure that the amount the residents were receiving is accurate per physician orders and documented correctly on the MAR.
3. In-Service education was conducted on January 5, 2012 by Clinical Coordinators with all licensed nursing staff regarding verifying physicians' orders for water bolus against the MAR for each resident. The in-service also included review of the facility policy and procedure for transcribing to the MAR when a physician order is received.
4. The Quality Assurance Committee designee will review the resident records to assure that water bolus are administered in accordance with current physician orders and are transcribed accurately to the MAR of each resident. A total of 5 records will be reviewed weekly for one month and then 5 records reviewed monthly for three months. Any irregularity will be corrected immediately and reported to the Quality Assurance Committee for further review.
5. Date of Completion: February 1, 2012

F.441

1. Resident #1 is receiving incontinence care in accordance with facility Infection Control policy and procedure and in accordance with accepted professional practice regarding hand washing.
2. All residents of the facility are receiving incontinence care and services will get services in accordance with the Infection Control policy of the facility. Staff are utilizing gloves and washing hand appropriately.
3. In-service education on incontinence care hand washing and glove changing with nursing staff was conducted on January 6, 2012 by the Clinical Coordinator. Education included providing incontinence care services in accordance with facility Infection Control policy and procedures and accepted professional practice for hand washing and glove changing.
4. The Quality Assurance Committee designee will review incontinence care and services are provided to incontinent residents on various shifts. The review will include observing nurse aides providing incontinence care to 5 residents per week on various shifts for one month and then 5 residents per month for three months. These observations will specifically focus on hand washing and glove changing during care. Any irregularities will be corrected immediately and referred to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

F 496

1. Nurse Aide # 3 certification was verified as active and filed in personnel records.
2. All nurse aides' personnel files were reviewed and verified.
3. In-service was conducted by Administrator with staff member in charge of personnel records on January 6, 2012. The designated staff member will obtain and maintain nurse aide active status verification on the Kentucky Board of Nursing Registry.
4. The Quality Assurance Committee designee will conduct an audit of nurse aides' records to verify that each has an active status on the Kentucky Board of Nursing Registry. All new hires will be reviewed by the designee as well to verify certification is active. The audit will include a review of Nurse Aide personnel records to assure that no nurse aide is working with a lapsed certification and that proof of active status certification is on file. Five records will be reviewed weekly for one month and then 5 records monthly for three months. Any irregularity will be corrected immediately and referred to the Quality Assurance Committee for further review.
5. Date of Completion : February 1, 2012

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2012
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 618 HYDEN, KY 41749		
(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>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Four</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 01/04/12, 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.</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.