

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

PRINTED: 06/26/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/12/2014
NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
(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 Recertification Survey was conducted on 06/10/14 through 06/12/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E."

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the facility's policy/procedure, the facility failed to provide care in accordance with the plan of care for one (1) resident (#2), in the selected sample of fourteen (14) residents. Observations during the survey revealed the resident was sitting alone in his/her room, and up in the wheelchair. A pressure sensor alarm pad was noted on his/her bed with an alarm control box strapped to the side rail on the right side of the bed.

Findings include:

Review of the facility's policy/procedure titled "Care Plans", revised 01/02/14, revealed a comprehensive, individualized care plan will be developed by the interdisciplinary team for each resident. The care plan should include measurable objectives to meet resident needs and goals as identified by the assessment

F 000 "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Hillside Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 282

The Licensed Nurse applied tags alarm/fall device to resident #2 per care plan on 6/12/14. Resident #2 was assessed by a Licensed Nurse on 6/12/14 for alarm continuation.

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

*Carol L. Britt*

TITLE

*Administrator*

(X6) DATE

*07/03/14*

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 282 Continued From page 1  
process. Additionally, a review of the facility's policy/procedure titled "Falls Management", undated, revealed residents will be assessed for falls as part of the nursing assessment process. Those residents determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.

Record review revealed Resident #2 was admitted to the facility on 12/05/13 with diagnoses to include Cardiopulmonary Disease (COPD), Fractured Upper Leg, Weakness, Pneumonia, Dementia, Malnutrition, Urinary Tract Infection (UTI), Anxiety, Gastroesophageal Reflux Disease (GERD), Hypertension (HTN), and Anemia. Review of the admission Minimum Data Set (MDS) assessment, dated 04/23/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15). Further review of the admission MDS assessment revealed the resident was to be transferred with extensive assistance of two (2) staff.

Review of the Fall Risk Evaluation, dated 03/29/13, revealed a score of nineteen (19), with a score of twelve (12) or greater indicating the resident was at high risk for fall.

Review of the Comprehensive Care Plan, dated 11/12/13 and reviewed 05/02/14, revealed the resident was care planned to have a pressure alarm in place at all times. Review of the MDS Kardex Report sheet (identified as Certified Nurse Aide (CNA) care card), dated 06/2014, also revealed the resident was to have a pressure alarm in place at all times.

Observations, on 06/10/14 at 10:35 AM, 11:39

F 282 Current residents with assistive/fall devices were reviewed by Director of Nursing, Assistant Director of Nursing or Licensed Nurse to ensure devices were implemented per Care Plans/Kardex on 6/13/14. No further concerns were identified.

The Nurse Practice Educator, re-educated the Licensed Nurses, Certified Nursing Assistants, Rehabilitation staff and Recreation staff on following resident care plans to include placement of assistive/fall devices was initiated on 6/12/14 with completion on 6/16/14.

Five residents with assistive/fall devices will be reviewed across all shifts as per care plan by the Director of Nursing and/or the Assistant Director of Nursing two times a week for a month, then five residents per week for one month then five residents per month for one month to ensure care is being provided in accordance with each residents written plan of care. Corrective action and/or re-education will be provided at point of discovery. The Director of Nursing will report findings for three months to the monthly Performance Improvement Committee for further recommendations.

Completion Date: 6/25/14

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F 282	<p>Continued From page 2</p> <p>AM, and 2:00 PM, revealed the resident was sitting alone in his/her room in a wheelchair. Further observation revealed a pressure sensor alarm pad was noted on his/her bed with an alarm control box strapped to the side rail on the right side of the bed.</p> <p>Interview with CNA #1, on 06/10/14 at 2:53 PM, revealed Resident #2 was to have a pressure alarm in place at all times while in the bed and up in the wheelchair. She stated the alarms were to be checked every two (2) hours and anytime care was provided.</p> <p>Interview with CNA #2, on 06/11/14 at 1:34 PM, revealed the facility mostly used pressure alarms for bed use and tab alarms while up in wheelchairs; however, either device could be used depending on the care plan. Each alarm device was care planned separately. She stated a care plan for a pressure alarm at all times meant if in the bed, a pressure alarm was placed on the bed. If up in a chair, the pressure alarm was placed on the chair.</p> <p>Interview with CNA #3, on 06/11/14 at 1:47 PM, revealed the staff was expected to check pressure alarms at the beginning of the shift, at the end of the shift, and every time care was provided for a resident. She stated if a care plan indicated a pressure alarm was to be used at all times, she would expect a pressure alarm to be in place and the alarm turned on anytime the resident was out of view of the staff member.</p> <p>Interview with Licensed Practical Nurse (LPN) # 1, on 06/10/14 at 2:43 PM, revealed if a resident was care planned for a pressure alarm at all times, the pressure alarm should be in place if</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>the resident was in bed, in a chair, or a wheelchair at all times.</p> <p>Interview with LPN #2, on 06/11/14 at 2:01 PM, revealed pressure alarm use meant the resident had decreased safety awareness. She stated pressure alarms were marked on the CNA care card, the comprehensive care plan was updated, and staff were verbally informed about any new orders when a pressure alarm was ordered. She stated a pressure alarm at all times meant while in the bed, chair, or wheelchair. Rounds were completed every two (2) hours to verify the alarms were in place and functioning. If the alarm was not working, the CNA should report any failure to the nurse, who should replace the batteries or the alarm device as needed.</p> <p>Interview with Registered Nurse (RN) #1, on 06/11/14 at 2:23 PM, revealed pressure alarms were checked by licensed staff on every twelve (12) hour shift and every two (2) hours or if in the room providing care. She stated the CNA care plan indicated Resident #2 should have a pressure alarm device at all times, and if a care plan indicated a pressure alarm at all times, that meant while in the bed, a chair or a wheelchair. A fall investigation or fall assessment was used to indicate the need for a pressure alarm. He expected a pressure alarm should be utilized according to the care plan.</p> <p>Interview with the Assistant Director or Nursing (ADON), on 06/11/14 at 2:55 PM, revealed each nurse should check alarms every twelve (12) hours. The CNA should check the alarm every two (2) hours when doing rounds to ensure they were functioning. If a care plan indicated a pressure alarm at all times, this meant while the</p>	F 282		

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F 282 Continued From page 4  
resident was in the bed, a chair, or a wheelchair. She expected if a pressure alarm was care planned, it should be utilized. She revealed a pressure alarm would be indicated if a resident was assessed as high fall risk or had a previous fall, and was determined by the Interdisciplinary (IDT) team. The charge nurse obtained an order and initiated the pressure alarm.

Interview with the Director of Nursing (DON), on 06/12/14 at 1:27 PM, revealed CNAs were to check pressure alarms every two (2) hours with rounds and nurses were to check alarms every shift. If a care plan indicated "Pressure alarm at all times", this meant the alarm should be in place while the resident was in bed, a chair, or a wheelchair. The alarms were used to alert the staff if a resident got up. She revealed a concern would be if the staff were unaware of the resident getting up and the alarms not being used.

F 323 483.25(h) FREE OF ACCIDENT  
SS=E HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate assistance devices to

F 282

F 323 F 323

The Licensed Nurse applied assistive/fall device to resident #2 per care plan on 6/12/14 while up in wheelchair. The Beauty Shop door was locked by the Maintenance Director on 6/10/14 at the time of discovery.

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F 323	<p>Continued From page 5</p> <p>prevent accidents for one (1) resident (#2), in the selected sample of fourteen (14) residents. Observations during the survey revealed the resident was sitting alone in his/her room, and up in the wheelchair. A pressure sensor alarm pad was noted on his/her bed with an alarm control box strapped to the side rail on the right side of the bed.</p> <p>Additionally, the facility failed to ensure the environment remained as free from accident hazards as is possible related to chemical storage in an unlocked beauty shop. The facility identified ten (10) residents at risk for wandering.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy/procedure titled "Falls Management", revised 05/15/14, revealed residents will be assessed for falls as part of the nursing assessment process. Those residents determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.</li> </ol> <p>Record review revealed Resident #2 was admitted to the facility on 12/05/13 with diagnoses to include Cardiolpmonary Disease (COPD), Fractured Upper Leg, Weakness, Pneumonia, Dementia, Malnutrition, Urinary Tract Infection (UTI), Anxiety, Gastroesophageal Reflux Disease (GERD), Hypertension (HTN), and Anemia. Review of the admission Minimum Data Set (MDS) assessment, dated 04/23/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15). Further review of the admission MDS assessment revealed the resident was to be transferred with extensive assistance of two (2) staff.</p>	F 323	<p>Current residents with assistive/fall devices were reviewed for placement and functionality by the Director of Nursing, Assistant Director of Nursing or Licensed Nurse on 6/12/14. No concerns were identified.</p> <p>The Maintenance Director conducted rounds in facility for securement of areas containing hazardous chemicals on 6/10/14 and no other areas were identified.</p> <p>The Nurse Practice Educator, Director of Nursing, Assistant Director of Nursing initiated re-educated with the Licensed Nurses, Certified Nursing Assistants, Rehabilitation staff and Recreation staff on 6/12/14 and completed on 6/16/14, on adequate supervision and assistive/fall devices to prevent accidents including following the care plans for application of assistive devices.</p> <p>The Beautician was re-educated by the Administrator on 6/11/14 on supervision and/or containment of hazards that are needed to protect residents from harm caused by chemicals, i.e. isopropyl alcohol including ensuring door is locked when the beauty shop is unattended.</p>

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F 323	Continued From page 6  Review of the Fall Risk Evaluation, dated 03/29/13, revealed a score of nineteen (19), with a score of twelve (12) or greater indicating the resident was at high risk for fall.  Review of the Comprehensive Care Plan, dated 11/12/13 and reviewed 05/02/14, revealed the resident was care planned to have a pressure alarm in place at all times. Review of the MDS Kardex Report sheet (identified as Certified Nurse Aide (CNA) care card), dated 06/2014, also revealed the resident was to have a pressure alarm in place at all times.  Observations, on 06/10/14 at 10:35 AM, 11:39 AM, and 2:00 PM, revealed the resident was sitting alone in his/her room in a wheelchair. Further observation revealed a pressure sensor alarm pad was noted on his/her bed with an alarm control box strapped to the side rail on the right side of the bed.  Interview with CNA #1, on 06/10/14 at 2:53 PM, revealed Resident #2 was to have a pressure alarm in place at all times while in the bed and up in the wheelchair. She stated the alarms were to be checked every two (2) hours and anytime care was provided.  Interview with CNA #2, on 06/11/14 at 1:34 PM, revealed the facility mostly used pressure alarms for bed use and tab alarms while up in wheelchairs; however, either device could be used depending on the care plan. Each alarm device was care planned separately. She stated a care plan for a pressure alarm at all times meant if in the bed, a pressure alarm was placed on the bed. If up in a chair, the pressure alarm was		F 323	Five residents with assistive/fall devices will be checked across all shifts by the Director of Nursing, Assistant Director of Nursing two times a week for a month, then five per week for one month then five per month for one month to ensure placement and function to prevent accidents. Corrective action and/or re-education will be provided at point of discovery. The Maintenance Director or assigned staff member will complete rounds following the Beautician closing beauty shop each week for 4 weeks then as determined by the monthly Performance Improvement Committee to ensure door is locked with corrective action upon discovery. Findings will be reported to the Administrator for additional follow up, if indicated with the Beautician. The Director of Nursing and Maintenance Director will report findings to the monthly Performance Improvement Committee for three months for further recommendations.  Completion Date:	06/25/14

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F 323	<p>Continued From page 7 placed on the chair.</p> <p>Interview with CNA #3, on 06/11/14 at 1:47 PM, revealed the staff was expected to check pressure alarms at the beginning of the shift, at the end of the shift, and every time care was provided for a resident. She stated if a care plan indicated a pressure alarm was to be used at all times, she would expect a pressure alarm to be in place and the alarm turned on anytime the resident was out of view of the staff member.</p> <p>Interview with Licensed Practical Nurse (LPN) # 1, on 06/10/14 at 2:43 PM, revealed if a resident was care planned for a pressure alarm at all times, the pressure alarm should be in place if the resident was in bed, in a chair, or a wheelchair at all times.</p> <p>Interview with LPN #2, on 06/11/14 at 2:01 PM, revealed pressure alarm use meant the resident had decreased safety awareness. She stated pressure alarms were marked on the CNA care card, the comprehensive care plan was updated, and staff were verbally informed about any new orders when a pressure alarm was ordered. She stated a pressure alarm at all times meant while in the bed, chair, or wheelchair. Rounds were completed every two (2) hours to verify the alarms were in place and functioning. If the alarm was not working, the CNA should report any failure to the nurse, who should replace the batteries or the alarm device as needed.</p> <p>Interview with Registered Nurse (RN) #1, on 06/11/14 at 2:23 PM, revealed pressure alarms were checked by licensed staff on every twelve (12) hour shift and every two (2) hours or if in the room providing care. She stated the CNA care</p>	F 323		

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F 323	Continued From page 8 plan indicated Resident #2 should have a pressure alarm device at all times, and if a care plan indicated a pressure alarm at all times, that meant while in the bed, a chair or a wheelchair. A fall investigation or fall assessment was used to indicate the need for a pressure alarm. He expected a pressure alarm should be utilized according to the care plan.  Interview with the Assistant Director or Nursing (ADON), on 06/11/14 at 2:55 PM, revealed each nurse should check alarms every twelve (12) hours. The CNA should check the alarm every two (2) hours when doing rounds to ensure they were functioning. If a care plan indicated a	F 323		
	pressure alarm at all times, this meant while the resident was in the bed, a chair, or a wheelchair. She expected if a pressure alarm was care planned, it should be utilized. She revealed a pressure alarm would be indicated if a resident was assessed as high fall risk or had a previous fall, and was determined by the Interdisciplinary (IDT) team. The charge nurse obtained an order and initiated the pressure alarm.  Interview with the Director of Nursing (DON), on 06/12/14 at 1:27 PM, revealed CNAs were to check pressure alarms every two (2) hours with rounds and nurses were to check alarms every shift. If a care plan indicated "Pressure alarm at all times", this meant the alarm should be in place while the resident was in bed, a chair, or a wheelchair. The alarms were used to alert the staff if a resident got up. She revealed a concern would be if the staff were unaware of the resident getting up and the alarms not being used.  2. Review of the facility's Storage policy, revised 11/01/07, revealed storage areas were locked			

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F 323	Continued From page 9 when not in operation to prevent unauthorized access.  Review of the Material Safety Data Sheet (MSDS) for Isopropyl Alcohol, updated 05/21/13, revealed it was hazardous in case of eye contact, ingestion, or inhalation.  Observation, on 06/10/14 at 1:00 PM, revealed one (1) partially used bottle of Isopropyl alcohol located on a table in the unlocked beauty shop.  Interview with the Administrator, on 06/12/14 at 8:30 AM, revealed she expected the beauty shop door to remain locked at all times when not in use.	F 323	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent (%) or greater. Twenty-seven (27) medication opportunities with three (3) medication errors equaled an eleven (11) % medication error rate.  Findings include:  Review of the facility's Medication Administration policy/procedure, revised 01/02/14, revealed	F 332	F 332  Resident A's Physician was notified by a Licensed nurse on 6/11/14 and new orders received and implemented on that date. Resident A was reassessed on 6/11/14 by a Licensed Nurse for signs and symptoms of medication reactions and none were identified. Licensed Nurse #1 was re-educated on 6/11/14 by Assistant Director of Nursing on five rights of medication administration, including utilization of the do not crush list, and delayed/extended release medication administration with Clinical Competency validation for med pass completed prior to continuation of med pass.

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F 332	Continued From page 10  accepted standards of practice would be followed. The facility would provide a safe, effective medication administration process.  Review of the "Common Oral Dosage Forms that Should Not Be Crushed" list, undated, revealed Diclofenac Sodium should not be crushed as it was a delayed release medication. Metoprolol Succinate was listed as it was an extended release medication. Namenda XR should not be crushed as it was extended release; however, it could be sprinkled on applesauce.  Observation of a medication pass for an unsampled resident (A), on 06/11/14 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #3 crushed and administered the following medications to the resident in applesauce: 1. Diclofenac Sodium (Non-Steroidal Anti-Inflammatory Drug) Enteric Coated (EC) 75 milligrams (mg) tablet 2. Metoprolol Succinate Extended Release (ER) 25 mg tablet 3. Namenda XR (extended release) 28 mg capsule  Record review revealed Resident (A) was admitted to the facility on 06/25/12 with diagnoses to include Schizophrenia, Senile Dementia, and Hypertension. Review of the Physician's Orders, dated 06/11/14, revealed the facility could crush "crushable" medications. The orders revealed an order for the following: 1. Diclofenac Sodium Delayed Release 75 mg tablet every 12 hours for mild pain 2. Metoprolol Succinate ER tablet 25 mg once daily for Hypertension 3. Namenda XR 28 mg capsule once daily for Senile Dementia		F 332 Current residents were reassessed on 6/11/14 by a Licensed Nurse for signs and symptoms of medication reactions and none were identified.  Director of Nursing, Assistant Director of Nursing initiated re-education for 15 of 15 Licensed Nurses on five rights of medication administration including utilization of the do not crush list, and delayed/extended release medication administration, on 6/11/14 and completed on 6/16/14. Med Pass observations were completed for 15 of 15 Licensed Nurses on each shift by the Director of Nursing or Assistant Director of Nursing beginning on 6/11/14 through 6/22/14.  The Director of Nursing, Assistant Director of Nursing or Pharmacy Personnel will monitor med pass via observation randomly for medications that are crushed at least four times per week across all shifts for 30 days then no less than two times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. The Director of Nursing will report findings to the monthly Performance Improvement Committee for three months for further recommendations.
			Completion Date: 6/25/14

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NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
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F 332	Continued From page 11  Interview with Pharmacist #1, on 06/11/14 at 10:00 AM, revealed crushing an EC tablet, such as Diclofenac Sodium, could potentially cause gastrointestinal (GI) problems as the enteric coating delays absorption in the GI tract. Crushing ER medications, such as Metoprolol Succinate and Namenda XR, release all of the medication at once instead of an extended period of time. He revealed no ER medication should be crushed.  Interview with LPN #3, on 06/11/14 at 10:25 AM, revealed she does not typically crush ER or EC pills/capsules; however, Resident (A) would not be able to swallow them whole.	F 332	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was	F 333	Resident A's Physician was notified by a Licensed nurse on 6/11/14 and new orders received and implemented on that date. Resident A was reassessed on 6/11/14 by a Licensed Nurse for signs and symptoms of medication reactions and none were identified. Licensed Nurse #1 was re-educated on 6/11/14 post error by Assistant Director of Nursing on five rights of medication administration, including utilization of the do not crush list, and delayed/extended release medication administration with Clinical Competency validation for med pass completed prior to continuation of med pass.

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F 333	<p>Continued From page 12</p> <p>determined the facility failed to ensure residents were free of any significant medication errors for one resident (A), not in the selected sample. Licensed Practical Nurse (LPN) #3 crushed a Namenda XR (extended release) 28 milligram (mg) capsule and administered it to Resident (A).</p> <p>Findings include:</p> <p>Review of the facility's Medication Administration policy/procedure, revised 01/02/14, revealed accepted standards of practice would be followed. The facility would provide a safe, effective medication administration process.</p> <p>Review of the "Common Oral Dosage Forms that Should Not Be Crushed" list, undated, revealed Namenda XR should not be crushed as it was extended release; however, it could be sprinkled on applesauce.</p> <p>Observation of a medication pass for Resident (A), on 06/11/14 at 9:00 AM, revealed LPN #3 crushed and administered a Namenda XR (extended release) 28 mg capsule in applesauce to the resident.</p> <p>Record review revealed Resident (A) was admitted to the facility on 06/25/12 with a diagnosis of Senile Dementia. Review of the Physician's Orders, dated 06/11/14, revealed the facility could crush "crushable" medications. The orders revealed to administer Namenda XR 28 mg capsule once daily for Senile Dementia.</p> <p>Interview with Pharmacist #1, on 06/11/14 at 10:00 AM, revealed crushing extended release medications, such as Namenda XR, release all of the medication at once instead of an extended</p>	F 333	<p>Current residents were reassessed on 6/11/14 by a Licensed Nurse for signs and symptoms of medication reactions and none were identified.</p> <p>Director of Nursing, Assistant Director of Nursing initiated re-education for 15 of 15 Licensed Nurses on five rights of medication administration including utilization of the do not crush list, and delayed/extended release medication administration, on 6/11/14 and completed on 6/16/14. Med Pass observations were completed for 15 of 15 Licensed Nurses on each shift by the Director of Nursing or Assistant Director of Nursing beginning on 6/11/14 through 6/22/14.</p> <p>The Director of Nursing, Assistant Director of Nursing or Pharmacy Personnel will monitor med pass via observation randomly for medications that are crushed at least four times per week across all shifts for 30 days then no less than two times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery.</p> <p>The Director of Nursing will report findings to the monthly Performance Improvement Committee for three months for further recommendations.</p> <p>Completion Date: 6/25/14</p>

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F 333	Continued From page 13 period of time. He revealed Namenda was generally given as 10 mg twice daily; therefore, crushing the Namenda XR capsule would cause the resident to get twice the regular dose at once. He revealed the extended release capsule was designed to release the medication over a 24 hour time period. Crushing the medication could cause the resident to have increased drowsiness, dizziness, or increased/decreased blood pressure.  Interview with Pharmacist #2, on 06/12/14 at 9:45 AM, revealed extended release capsules typically have coated pellets inside that should not be crushed; however, it would be acceptable to open the capsule and sprinkle the pellets on applesauce.  Interview with LPN #3, on 06/11/14 at 10:25 AM, revealed she does not typically crush extended release capsules; however, Resident (A) would not be able to swallow the medication whole.  Interview with the Director of Nursing (DON), on 06/12/14 at 9:00 AM, revealed she expected the staff to refer to the "do not crush" list in the front of the Medication Administration Record (MAR). She revealed staff should not crush extended release capsules, and should notify the physician for further orders if a resident was unable to swallow the medication whole.	F 333			
F 371 SS=E	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	F 371 F 371	Food Service Director discarded the aluminum can of apricots and two containers of thickened sweetened tea on 6/10/14.		

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F 371	<p>Continued From page 14</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturer's guidelines, and the facility's policy/procedure, it was determined the facility failed to ensure food was stored in the refrigerator under sanitary conditions. The census of the facility was fifty-four (54) residents with eight (8) residents requiring thickened liquids.</p> <p>Findings include:</p> <p>Review of the "Use By" Dating Guidelines, revised 10/06/13, revealed the "use by" date for ready-to-eat foods was seven (7) days after opening. The manufacturer's instructions for "use by" date of opened items overrides the guidelines. The guidelines assume that food was properly stored, covered, and handled.</p> <p>Review of the manufacturer's guidelines for nectar-like consistency Thickened Sweetened Tea, undated, revealed to refrigerate up to five (5) days once opened.</p> <p>Observation in the refrigerator, on 06/10/14 at 8:40 AM, revealed the following:</p> <ol style="list-style-type: none"> <li>Two (2) containers of nectar-like consistency Thickened Sweetened Tea, opened and undated</li> <li>Apricot halves stored in the aluminum can, opened, uncovered, and undated</li> </ol>	F 371	<p>Food Service Director completed Sanitation review on 6/10/14 to include storage, preparation, distribution and food service under sanitary conditions; no other concerns identified. Sanitation review was completed by Regional District Manager of Dietary Services on 6/12/14 with no concerns identified.</p> <p>Food Service Director re-educated dietary staff on storage, preparation, distribution and food service under sanitary conditions, to include proper dating and covering of food on 6/10/14 through 6/11/14.</p> <p>Sanitation reviews will be completed daily for two weeks, twice a week for two weeks, then monthly for two months by the Food Service Director. Corrective action and/or re-education will be provided at point of discovery. The Food Service Director will report findings to the monthly Performance Improvement Committee for three months for further recommendations.</p> <p>Completion Date:</p>	6/25/14

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F 371	Continued From page 15  Interview with the Food Service Director, on 06/10/14 at 8:55 AM, revealed she expected staff to date items in the refrigerator when opened. She revealed canned foods should be immediately put into a different container once opened, then covered when stored in the refrigerator.  Interview with the Administrator, on 06/12/14 at 8:30 AM, revealed she expected staff to follow the policy related to food storage in the refrigerator.	F 371		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01.  PLAN APPROVAL: 1969.  SURVEY UNDER: 2000 Existing.  FACILITY TYPE: SNF/NF.  TYPE OF STRUCTURE: One (1) story, Type III (211).  SMOKE COMPARTMENTS: Four (4) smoke compartments.  FIRE ALARM: Complete fire alarm system installed in 1969 with 0 smoke detectors and 99 heat detectors.  SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1969 and upgraded in 2009.  GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.  A standard Life Safety Code Survey was conducted on 06/12/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-one (71) beds with a census of fifty-four (54) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Hillside Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Carol L. Britt Administrator* TITLE: \_\_\_\_\_ (X6) DATE: 07/03/14

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 000	Continued From page 1 Fire).  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-one (71) beds and at the time of the survey, the census was fifty-four (54).  The findings include:  Observation, on 06/12/14 at 10:25 AM with the Maintenance Supervisor, revealed the exit sign located in the dryer room was not illuminated.  Interview, on 06/12/14 at 10:26 AM with the Maintenance Supervisor, revealed he was unaware the exit signs in the facility were required to be illuminated.  Observation, on 06/12/14 at 10:31 AM with the Maintenance Supervisor, revealed the exit sign	K 047 K 047	Maintenance Director installed illuminated exit signs on both sides of the 300/400 hall fire doors, above the out door exit of dietary, and on both sides of the 200 hall fire doors on 6/20/14. The non-illuminated exit sign in laundry was identified as not being needed and was discarded 6/20/2014.  Maintenance Director reviewed facility exits for illuminated signs per NFPA Standards; no other concerns identified or corrected on 6/12/14.  Maintenance Director was re-educated on NFPA 101 Life Safety Code Standard in regards to illuminated exit signs by Administrator on 6/12/14.	

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K 047	<p>Continued From page 2</p> <p>located above the 300 fire doors was not illuminated.</p> <p>Interview, on 06/12/14 at 10:32 AM with the Maintenance Supervisor, revealed he was unaware the exit signs in the facility were required to be illuminated.</p> <p>Observation, on 06/12/14 at 10:42 AM with the Maintenance Supervisor, revealed the exit sign located above the 400 fire doors was not illuminated.</p> <p>Interview, on 06/12/14 at 10:43 AM with the Maintenance Supervisor, revealed he was unaware the exit signs in the facility were required to be illuminated.</p> <p>Observation, on 06/12/14 at 10:55 AM with the Maintenance Supervisor, revealed an exit sign on one side of the 400 doors.</p> <p>Interview, on 06/12/14 at 10:56 AM with the Maintenance Supervisor, revealed he was unaware the exit signs were required on each side of the fire doors.</p> <p>Observation, on 06/12/14 at 12:45 PM with the Maintenance Supervisor, revealed no exit signs on either side of the 200 fire doors.</p> <p>Interview, on 06/12/14 at 12:46 AM with the Maintenance Supervisor, revealed he was unaware the exit signs were required on each side of the fire doors.</p> <p>The census of fifty-four (54) was verified by the Administrator on 06/12/14. The findings were</p>	K 047	<p>Administrator will review facility for illuminated exit signs per NFPA 101 Life Safety Code Standard weekly times four and monthly times two months. Corrective action and/or re-education will be provided at point of discovery. The Administrator will report findings monthly times three months to the Performance Improvement Committee for further recommendations.</p> <p>Completion Date: 07/02/14</p>

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K 047	Continued From page 3 acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/12/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition)  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.  7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 047		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 052  Fire Alarm system was rewired by VanGuard to separate building into 5 zones to ensure it is installed, tested and maintained in accordance with NFPA Code 70 and 72 on 6/30/14.	

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K 052	Continued From page 4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with NFPA Standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-one (71) beds and at the time of the survey, the census was fifty-four (54).  The findings include:  Observation, on 06/12/14 at 1:18 PM with the Maintenance Supervisor, revealed once the fire alarm was placed in silent mode it would not re-alarm when another pull station was pulled.  Interview, on 06/12/14 at 1:18 PM with the Maintenance Supervisor, revealed he was unaware the fire alarm was supposed alarm again if another pull station was pulled.  The census of fifty-four (54) was verified by the Administrator on 06/12/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/12/14.  Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required	K 052	VanGuard inspected the fire alarm system on 6/13/14 and validated findings. No other concerns noted.  Maintenance Director was re-educated on NFPA 70 and 72 on an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72 by Administrator on 6/12/14.  Administrator will review fire alarm system monthly for three months per NFPA Code and will review quarterly Fire Alarm Inspection Report from VanGuard for one quarter. Corrective action and/or re-education will be provided at point of discovery. The Administrator will report findings monthly times one then quarterly for six months to the Performance Improvement Committee for further recommendations.  Completion Date:	07/02/14