

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

PRINTED: 09/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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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
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F 000: INITIAL COMMENTS

A Recertification Survey was initiated on 09/09/14 and concluded on 09/12/14 with deficient practice identified at the highest scope and severity of an "F."

F 155: 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

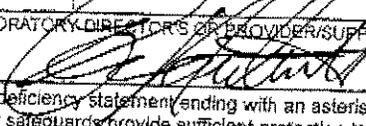
The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents' Advanced directives were current and accurately documented in the Residents' record for five (5) of nineteen (19)

F 000:

F 155: "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Grant 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."

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	DATE 10/8/14
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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 155: Continued From page 1
sampled residents (Residents #5, #7, #8, #15 and #18). Review of the records revealed the "code status" the facility had documented did not match the Comprehensive Care Plan and/or the current Physician's Orders.

The findings include:

Review of the facility's policy titled, "NSG208: Cardiac and/or Respiratory Arrest," with an effective date of 06/01/96 and revision date of 01/02/14, revealed cardiopulmonary resuscitation (CPR), will be performed on all patients, except in certain limited circumstances, unless there is a written Physician's order, agreed to by the patient or health care decision maker, not to resuscitate (DNR) in accordance with state regulation/law. Patient identification and information about each patient's DNR status will be easily accessible to direct care nursing staff for all patients.

1. Review of Resident #5 record revealed the facility admitted the resident on 01/11/13 with diagnoses which included Alzheimer's Dementia, Urinary Tract Infection, confusion, anxiety, pain, and history of falls. Further review of the resident's record revealed, the page inside the front of the chart listing Emergency Code Status had a DNR label. Review of the "Kentucky Emergency Medical Services DNR Order" form in the record revealed Resident #5's spouse had signed the form as a DNR, dated 05/16/14 with two (2) witnesses. Review of the facility's form "Request For Do Not Initiate Cardiopulmonary Resuscitation (DNR)" was signed and dated by Resident #5 s' spouse, Physician and witness on 05/20/14. Review of the Care Plan for Resident #5 revealed DNR was Care Planned 05/12/14. However, review of the Physician's orders, dated

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F 155	<p>Continued From page 2</p> <p>08/29/14, revealed an order for Full Code with an origination date of 05/12/14.</p> <p>Interview, on 09/11/14 at 2:05 PM, with the Director of Nursing (DON) revealed Resident #5's record was checked but the Code Status was not changed and the error was carried over to 09/09/14. She stated the Unit Manager, Assistant Director of Nursing (AODN) and some night managers review the Physician's orders.</p> <p>2. Review of Resident #7 record revealed the facility readmitted the resident on 04/21/14 with diagnoses which included Dementia, Depression, Anxiety, and Diabetes Type Two (2). Further review of Resident #7's record revealed, the page inside front of chart listing Emergency Code Status had a Full Code label with hand written CPR Only, No intubation and Okay for cardioversion. Review of the "Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order" signed by Resident #7's Power of Attorney (POA) and two (2) witnesses dated 07/01/14. Review of the facility's form "Request For Do Not Initiate Cardiopulmonary Resuscitation (DNR)" revealed it was signed by the POA and witness on 07/01/14. Review of the resident's "History and Physical" dated 08/09/14 revealed a note by the Physician that the Code Status was reviewed. Review of the Physician's orders for 08/29/14 revealed Full Code Active order with an origination dated of 04/21/14. Review of Comprehensive Care Plans revealed CPR with an initiation date of 04/11/14.</p> <p>Interview, on 09/10/14 at 3:40 PM, with Registered Nurse (RN) #2/Unit Manager revealed based on the form in the front of the record, Resident #7 would be sent out as a Full Code.</p>	F 155	<p>F155</p> <p>1. Resident #5 received an order on September 9, 2014 for Do Not Resuscitate (DNR) and care plan revised. Resident #7 DNR order obtained on September 10, 2014 and care plan revised. Resident #8 code status order obtained on September 9, 2014 and care plan revised. Resident # 15 DNR obtained on September 9, 2014 and care plan revised. Resident # 18 is no longer in the facility.</p> <p>2. The Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers/Social Service Director/Activities Director/Health Information Manager Coordinator/MDS Nurse conducted a chart audit on September 9, 2014. Charts were reviewed for code status order, code status sticker, code status care plan, and Kentucky Emergency Medical Services DNR order form to determine policy and procedures are followed regarding advanced directives. No areas of concerns were identified.</p>	
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F 155: Continued From page 3

She revealed she did not see the Consent signed by the POA for DNR Status and on the Facility Form dated 07/01/14. She stated Physician had not signed the Facility DNR form and the current Physician's Order dated 04/21/14 listed Full Code.

3. Review of Resident #8 record revealed the facility admitted the resident on 07/31/14 with diagnoses which included Methicillin Resistant Staphylococcus Aureus, Dementia, and Peripheral Vascular Disease. Further review revealed a Physician's order for Full Code Status, as of 07/31/14. However, additionally noted in the medical record was a Do Not Resuscitate (DNR) sticker, along with a consent for DNR signed by Resident #8 on 08/08/14 and signed by the Physician on 08/26/14.

4. Review of Resident #15 record revealed the facility admitted the resident on 01/11/13 with diagnoses which included Unspecified Peripheral Vascular Disease and Dementia. Review of Resident #15's medical record revealed the Physician's orders for the month of September 2014 identified Resident #15 as desiring CPR. Review of comprehensive MD orders for July and August 2014 both identified Resident #15 as a DNR. Review of Resident #15's Condition Alert Tab further identified Resident #15 as DNR.

Interview with RN #1 on 09/12/14 at 9:29 AM revealed Resident #15 went to hospital as a DNR, and the nurse that did his/her readmit put CPR. RN #1 revealed if a resident was readmitted, she would call and verify code status, although she was not sure what the policy was. RN #1 went on to reveal she would look in the front of the chart to the Condition Tab Alert to determine a resident's code status. RN #1 revealed she was

F 155:

3. The Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Supervisors will re-educate Licensed Nurses on advance directives on or before October 20. This re-education will include review of physician orders for a DNR or CPR code status, and Kentucky Emergency Medical Services DNR form and care plan revision if indicated. The Director of Nursing and or the Assistant Director of Nursing will administer a post test to determine competency.

4. Code status compliance audits to ensure code status and care plan match will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or Nursing Supervisors two times weekly on 5 charts for 4 weeks then one time weekly on 5 charts for 8 weeks. Any areas of concern will be corrected when identified. The results of the audit will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion dates: 10/21/14

10/21/14

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F 155	<p>Continued From page 4</p> <p>not sure who was responsible for updating the condition alert page, although she assumed it was updated when there was a change of code status, and the nurse who documented changes would be responsible.</p> <p>5. Record review revealed Resident #18 was admitted to the facility on 05/29/14 with diagnoses which included Chronic Kidney Disease Stage III, Bacteremia, and Other Peripheral Vascular Disease. Review of Resident #18's medical record revealed the Condition Tab Alert identified Resident #18 as a DNR. Review of the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order, dated 05/29/14 and signed by the residents POA, revealed only one witness signed the form.</p> <p>Interview with the DON on 09/11/14 at 5:22 PM revealed as the form was not witnessed by two people, EMTs would be obligated to attempt resuscitation. The DON went on to reveal forms get checked upon admission by the admission nurse. Further, the DON revealed if any changes come about, an order is written, and the next day the order is reviewed in clinical meeting. The DON revealed the charts were checked by unit managers and/or nurse managers for completion the day after admission.</p> <p>Interview, on 09/12/14 at 11:55 AM, with Unit Manager #1 revealed the nurses were responsible for changing the Code Status, checking over Care Plans, and making changes immediately. If the Code Status on the Care Plan was not correct and didn't match the Advanced Directives the Unit Manager were to make the changes on the Care Plan.</p>	F 155		

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F 157 Continued From page 5
F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

F 157
F 157

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to inform the resident

F157

1. Resident #12 Power of Attorney was notified September 10, 2014 regarding resident #12 recently attended dermatological appointment.

2. The Director of Nursing/Assistant Director of Nursing and or Nursing Unit Managers/Supervisors using October appointment calendar will call Power of Attorneys to verify that the POAs are aware of the scheduled appointments on or before 10/20/14.

3. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Supervisors will re-educate Licensed Nurses on notification of the residents' legal representative of any change in condition to include appointments and documentation of the notification using a post test for competency on or before October 20, 2014.

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F 157 Continued From page 6
or the resident's legal representative of an appointment for one (1) of nineteen (19) sampled residents (Resident #12). Resident #12 had a dermatological appointment on 09/04/14 for which Resident #12 and Resident #12's POA were not informed.

The findings include:

Record review revealed Resident #12 was admitted to the facility on 02/09/10 with diagnoses which included Chronic Airway Obstruction NEC, Atrial Fibrillation, and Depressive Disorder NEC. The facility assessed Resident #12, in a Quarterly Minimum Data Set (MDS) dated 08/12/14, as an eleven (11) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) indicating the resident had moderate cognitive impairment.

Interview with Resident #12, on 9/10/14 at 8:18 AM, revealed he/she was told "last Wednesday at 8:30 AM" that he/she was being sent out for a 9:30 AM appointment to have cancer spots removed from his/her face. Resident #12 revealed he/she had not been informed previously of the appointment, and also that his/her son and Power of Attorney (POA) had not been informed of the appointment.

Interview with Resident #12's POA, on 09/12/14 at 4:30 PM, revealed the facility failed to inform him one (1) to two (2) weeks ago when Resident #12 had an appointment to remove cancerous growths.

Interview with the Director of Nursing (DON), on 09/12/14 at 5:12 PM, revealed she received a report from Resident #12's POA that he had not been contacted regarding the appointment. The

F 157

4. Director of Nursing/Assistant Director of Nursing and /or Nursing Unit Managers/Supervisors will call five residents' POAs from the appointment calendar per week for four weeks with appointments to validate that they have been notified and then three residents' POA from the appointment calendar per week for four weeks, and then one resident from the appointment calendar per week for four weeks. Results of the notification audit will be submitted to Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

10/21/14

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F 157	Continued From page 7 DON stated anytime they got an appointment, they were to contact the primary contact first to notify them, and second to see if they could go with the resident. The DON revealed there was no policy, it's just the facility's process. The DON went on to reveal the Transportation Coordinator had to get transportation scheduled within 72 hours, and the nurse was responsible for contacting the family. The DON went on to reveal she was not sure why the family wasn't contacted in this instance.	F 157		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and facility cleaning schedule, it was determined the facility failed to provide a clean, comfortable and homelike environment. Observation of the dayroom next to the piano revealed no evidence of being cleaned during the four day survey process; the same dirt and leaves were observed by the piano. On tour, the floor in room #307 was dirty and the shower room on Providence Unit had missing and crumpled tile, and a brown substance was noted under the shower chair. Additionally the shower room on Heritage Unit had a black substance in the grout lines of the shower stall and cracked tiles. On 09/10/14, room 403 had dried liquid in the	F 252	F252 1. The floor in the piano room was cleaned housekeeping staff on September 12, 2014. Room 307 was cleaned housekeeping staff on September 10, 2014 and the missing tile in the Providence shower room was ordered on September 19, 2014 and will be replaced on or before October 20, 2014 by Maintenance Director. The Providence shower chair was cleaned and disinfected on September 9, 2014, by nursing department. The grout in Heritage shower room tile was cleaned and disinfected on September 9, by housekeeping department. Heritage shower room cracked tile was ordered on September 19 by Maintenance Director and will be replaced on or before October 20 by Maintenance Director. Room 403 was cleaned on September 10, 2014 by housekeeping department.	

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F 252 Continued From page 8
doorway and tissues on the floor, giving the floor the appearance it had not been cleaned.

The findings include:

Review of the facility's policy "Cleaning and Disinfecting" revised date 07/01/14 revealed cleaning and disinfecting of patient care items and environment will be conducted based on risk for infection; clean items of all foreign materials such as blood, feces, dust or dirt before disinfecting. Further review revealed to clean environmental surfaces, floor, walls, furniture using approved hospital grade disinfectant according to schedule and as needed. Interview with the Housekeeping Director, on 09/09/14 at 8:45 AM, revealed there is no other policy on cleaning.

Review of the facility's policy "7-step Daily Washroom Cleaning", dated 01/01/2000 revealed the proper method to sanitize a washroom or bathroom in a long-term care facility; check supplies, empty trash, dust mop floor, clean and sanitize sink and tub, cleanse and sanitize commode, spot clean walls and/or partitions which includes wiping walls and damp mop floor. Further review revealed proper cleaning technique prevents the spread of infection.

Review of a work order request dated 07/24/14 for Providence Unit and 07/24/14 for Heritage Unit Shower Rooms revealed busted tiles; with remarks to be noted that stated "Looking for tiles". Further review of the Capital Items Plan for Fiscal Year 2015, dated 08/14/14 revealed a request to replace Shower and resident Bathroom flooring without mention of tiles.

F 252

2. Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Admissions Director, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Payroll/HR Manager, conducted environmental facility rounds to identify areas for cleanliness or repair concerns on or before October 20, 2014. Areas of concern identified will be corrected when found.

3. The Regional Housekeeping Manager re-educated the Housekeeping Supervisor and housekeeping staff on or before October 20, 2014 on the cleaning and disinfecting policy and procedure. A post test will be completed to determine competency. The Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/supervisors will re-educate nursing staff on the policy and procedure for cleaning and disinfecting shower chairs. A post test will be given to determine competency.

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F 252	<p>Continued From page 9</p> <p>Observation, on 09/09/14 at 9:40 AM, on initial tour of Heritage Unit revealed the shower stall in the unit bathroom had a black like substance at the base and down the grout line.</p> <p>Observation of the dayroom next to the piano showed no evidence of being cleaned during the four day survey process from 09/09/14 through 09/12/14; the same dirt and leaves were observed by the piano.</p> <p>Observation on initial tour of Providence, on 09/09/14 at 10:15 AM, revealed the unit shower room had cracked tile at the base of the wall where the floor joins the wall and crumbled tile on the shower floor; shower stall had a dried brown hard substance under the shower chair.</p> <p>Interview with Certified Nurses Assistant (CNA) #2, on 09/10/14 at 3:35 PM, revealed if a resident had a bowel movement during a shower it would be cleaned up by the CNA giving the shower and if left in the shower stall it would be an infection control concern. Further interview revealed the director of Nursing (DON) and Assistant director of Nursing (ADON) had recently had an inservice on this issue in the infection control meeting, date unknown.</p> <p>Interview with CNA #1 on 09/10/14 at 3:50 PM revealed, the CNA giving the shower should clean up the bowel movement and then tell housekeeping to disinfect it. Further interview revealed no bowel movement should be left in the shower because it could cause contamination.</p> <p>Observation, on 09/10/14 at 8:00 AM, revealed Room 403 with dried black liquid in the doorway and two (2) white tissue like substances on the</p>	F 252	<p>4. Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Dietary, Business Office Manager, and Maintenance Director, Assistant Director of Nursing, Payroll/HR manager, Nursing Unit Managers to conduct an environmental audit daily times two weeks then three times a week for four weeks, then two times a week for four weeks and then one time a week for 4 weeks. Audit results will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, monthly for 3 months for further review and recommendation.</p> <p>5. Completion date: October 21, 2014</p>	10/21/14	

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F 252	Continued From page 10 floor. Interview with the Housekeeping Director, on 09/10/14 and 09/11/14 at 8:45 AM, revealed they sanitized the showers after a resident had an accident, using disinfectant Quat. Further interview revealed the CNA had to notify housekeeping and bowel movement should not be left. Additional interview revealed housekeeping sanitized to keep the germs down. She did not know what the black substance in the grout lines and base of the floor on Heritage Unit was, although stated it should not be there and a cleaning schedule was supplied upon request. Interview with the Director of Nursing (DON), on 09/10/14 at 4:20 PM, revealed nursing staff need to clean up bowel movement in the shower room after a resident and then housekeeping should be called to disinfect. Further interview revealed brown substance should not of been left there. Interview with the Maintenance Director, on 09/09/14 at 10:20 AM, revealed he had not been able to find tiles to match the existing tiles, and he did not have documentation that reflected the repair of tiles. Further interview revealed there was no policy for submitting work orders/requests. Interview with the Administrator, on 09/11/14 at 8:35 AM, revealed the shower rooms were not homelike and did he not have a time frame when tiles would be repaired.	F 252			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	Continued From page 11 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the care plan was reviewed and revised for two (2) of nineteen (19) sampled residents, (Residents #1 and #8). The facility failed to revise Resident #1's care plan after the discontinuation of a Bi-pap machine and failed to revise Resident #8's care plan when the residents "Code Status" changed. The findings include: Review of the facility policy titled "Care Plans" with a revision date of 01/02/14, revealed the care plan will include measurable objectives to meet	F 280	F280 1. Resident #1's bi-pap machine was discontinued from her care plan Director of Nursing on September 12, 2014. Resident #8's care plan was revised by Social Service on September 9, 2014 to include DNR status. 2. Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers will conduct a care plan audit to verify care plans for code statuses and bi-pap machines were in place on or before October 20, 2014. Any areas of concern will be corrected upon discovery. 3. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/supervisors to re-educated Licensed Nurses on care plan policy and procedure to ensure the care plans reflect response to care and changing needs of the resident including code status and use of/discontinuation of bi-pap equipment on or before October 20, 2014. A post test will be given by Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Manager/supervisors to determine competency on or October 20, 2014.		

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F 280 Continued From page 12
patient needs and goals. Further review revealed the comprehensive care plan is reviewed and revised as needed to reflect response to care and changing needs and goals.

1. Record review revealed Resident #1 was admitted to the facility on 06/25/14 with diagnoses which included Neurogenic Bladder, Sleep Apnea, Morbid Obesity, Hypertension and Cardiac Dysrhythmias. Review of the Physician's orders dated 07/29/14 revealed an order to discontinue the Bi-pap machine. However, review of Resident #1's Care Plan dated 06/27/14, with a revision date of 08/20/14 revealed a goal to encourage resident to utilize Bi-pap machine while resting in bed and at night.

Interview with the Director of Nursing (DON), on 09/10/14 at 2:00 PM and 09/12/14 at 9:05 AM revealed the Bi-pap Care Plan should have been revised to discontinue the Bi-pap. She stated the nurse that received the order or the Nurse Manager was responsible for updating the Care Plans.

2. Record review revealed the facility admitted Resident #8 on 07/31/14 with diagnoses which included Methicillin Resistant Staphylococcus Aureus, Dementia, Peripheral Vascular Disease and Myocardial Infarction. Review of the medical record revealed a "Do Not Resuscitate" (DNR) sticker, along with a consent for DNR signed by the resident on 08/08/14 and the Physician on 08/26/14. However, review of the Comprehensive Care Plan, initiated on 08/02/14 revealed it had not been revised to include the DNR status.

Interview, on 09/12/14 at 11:10 AM, with the Minimum Data Set (MDS) Coordinator revealed

F 280

4. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Supervisors to review new physician orders daily Mon to Friday times 2 weeks to ensure care plans are updated to reflect changes in status including bi-pap/code status changes if indicated then two times a week for 4 weeks, then five charts one time a week for 8 weeks with corrective action if indicated. Audit results will be submitted to the Performance Improvement Committee, consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

10/21/14

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F 280	<p>Continued From page 13</p> <p>the process for Care Plan updates was to review any hand written notes between quarters, and to add any new information that needed to be added. Also, the MDS Coordinator revealed she looked for any resolved issues and added the date resolved to the Care Plans. The MDS Coordinator further revealed the Care Plans were revised by the Unit Manager and were reviewed by each discipline, in care conferences and by MDS.</p> <p>Interview, on 09/12/14 at 11:55 AM, RN Unit Manager #1 revealed the nurse was responsible for changing the Code Status and checking the Care Plans to make the change immediately. If the Code Status on the Care Plan was not changed the Unit Manager make the change to the Care Plan.</p> <p>Interview with the Administrator, on 09/12/14 at 12:15 PM, it was the responsibility of the Unit Manager to ensure Care Plans were revised.</p>	F 280		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Clinical Laboratory Improvement Amendments (CLIA) Standard and review of the manufacturer's guidelines for the BD Vacutainer Evacuated Blood Collection system, it was determined the facility failed to follow the professional recommended standards regarding the use of laboratory</p>	F 281		

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F 281 Continued From page 14

specimen containers. During the initial tour of the facility an inspection of the medication room revealed the storage of expired laboratory specimen containers.

The findings include:

According to the Clinical laboratory Improvement Amendments (CLIA) D5417 493.1252 Standard: Test systems, equipment, instruments, reagents, material, and supplies. (d) Reagents, solutions, culture media, Control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.

According to the manufacturer's recommendations regarding the BD Vacutainer Evacuated Blood Collection system for In Vitro Diagnostic Use, the laboratory tubes should not be used after their expiration date. Tubes expire on the last day of the month and year indicated.

Observation during the initial tour of the facility, on 09/09/14 at 3:00 PM, revealed nine (9) expired laboratory specimen containers in the laboratory container storage basket in the Providence Unit medication room. Two (2) red tubes had an expiration date of 07/14; three (3) red tubes had an expiration date of 04/14; one (1) red tube had an expiration date of 01/14; one (1) pink tube had an expiration date of 03/14; one pink (1) had an expiration date of 10/13; and one (1) green tube had an expiration date of 12/13.

An interview with Unit Supervisor/Registered Nurse (RN) #1, on 09/11/14 at 3:39 PM revealed that a nurse should check the expiration date on a laboratory specimen vial prior to drawing a lab

F 281

F281

1. All nine expired vaccutainers were properly disposed of by Director of Nursing on September 9, 2014.
2. Nursing Unit Managers audited the medication rooms for expired vaccutainers and supplies on September 9, 2014, no other areas of concern were identified.
3. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse Supervisors re-educated Licensed Nurses on the services provided or arranged by the facility must meet professional standards of quality including checking vaccutainers for expiration dates on or before October 20, 2014. A post test will be given to determine competency on or October 20, 2014

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F 281 : Continued From page 15
specimen because it could cause a false lab result.

An interview with the Director of Nursing (DON), on 09/10/14 at 2:30 PM revealed the facility was using a new laboratory and they brought their own supplies, but sometimes the facility did furnish the tubes, especially if it was a blood draw from a central line or Peripheral Intravenous Cutaneous Catheter (PICC) line. Continued interview revealed the lab currently sent over the lab specimen which they needed for routine lab draws every week. He stated it was the policy not to do monthly checks, but to check the lab tube right before they drew the lab specimen. Continued interview revealed they did not routinely check on the lab specimen supplies. He stated they did not do random audits or have a log.

An interview with the Laboratory Manager, at Med Lab which the facility used for processing laboratory specimens, on 09/12/14 at 10:35 AM, revealed the expiration date on the vacutainer (blood sample tubes) were specifically to address the efficacy of the vacuum of the tube containing additives; the efficacy of labs performed on blood samples in an expired tube would not be affected. He stated they checked sampled tubes for expiration dates when they arrived at the lab and would discard the specimen if the tube was expired.

F 281 :

4. Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers/Nurse Supervisors will audit medication room daily times two weeks then two times weekly for four weeks, then one time per week for 8 weeks to determine compliance. Audit results will be submitted to the Performance Improvement Committee, consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

10/21/14

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

SS=D

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

F 282 :

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F 282

Continued From page 16 care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Care Plan was followed for one (1) of nineteen (19) sampled residents, (Resident #1) related to reporting signs and symptoms of a Urinary Tract Infection (UTI) to the Physician.

The findings include:

Review of the facility's policy titled, "Indwelling Urinary Catheter", dated 06/01/96 revealed to report abnormal findings to a nurse or physician/mid-level provider.

Review of the facility's policy "Physician notification", with a revision date of 01/02/14 revealed upon identification of a patient with a change in condition a licensed nurse will perform appropriate clinical observation and data collection and report to Physician.

Record review revealed the facility admitted Resident #1 on 06/25/14 with diagnoses which included Neurogenic Bladder, Thromocytopenia, Hypertension, and Cardiac Dysrhythmias. Further review revealed Resident #1's Care Plan dated 07/03/14, with a revision date of 08/20/14, revealed an a care plan created on 07/28/14 for an Indwelling Foley with interventions to report to the Physician promptly if the urine contains any sediment, blood, cloudy, odorous material or if the resident has a fever. Further review of the progress notes for 08/03/14

F 282

F282

1. Resident #1's physician re-notified and nursing documentation completed regarding physician notification on October 3, 2014.

2. Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers/Nurse Supervisors identified like residents and assessed for in-dwelling catheter's patency, urine characteristics, and fever including need to notify physician on or before October 20, 2014.

3. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse Supervisors re-educated Licensed Nurses on physician notification guidelines and care plan policy on or before October 20, 2014. A post test will be given by Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse Supervisors on or before October 20, 2014.

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F 282: Continued From page 17
revealed Resident #1 had a temperature of 99.6 Farenheit and had no urinary output; however, there was no documented evidence the Physician was notified until 08/04/14.

Observation on 09/09/14 at 11:14 AM and 3:25 PM of Resident #1's Foley catheter revealed dark amber urine in drainage bag.

Interview with the Unit Manager and the Director of Nursing (DON), on 09/12/14 at 10:45 AM, revealed signs indicative of a UTI included elevated temperature, dark urine, altered mental status, abdominal tenderness, and sediment in urine. She stated if a resident had no urinary output and an elevated temperature, their concern would be a the resident had a possible blockage or sediment. Further interview revealed the Physician should have been notified as per the care plan and documentation should have been completed if the Physician was notified.

F 282:

4. Director of Nursing/Assistant Director of Nursing and or Nursing Unit Managers/Supervisors will conduct audit on two residents with in-dwelling catheters once weekly for four weeks, then one resident with in-dwelling catheter once a week for 8 weeks to determine compliance. Audit results will be submitted Performance Improvement Committee, consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

10/21/14

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.

F 315:

F315

1. Resident #1's catheter changed per monthly schedule on September 23, 2014 by licensed nurse. Resident #1 was assessed by Director of Nursing on October 3, 2014 and has no fever.

This REQUIREMENT is not met as evidenced by:

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F 315	<p>Continued From page 18</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents incontinent of bladder received appropriate catheter care for one (1) of nineteen (19) sampled residents, (Resident #1). The facility failed to ensure Resident #1's catheter was changed monthly as per the Physician's order.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Indwelling Urinary Catheter", dated 06/01/96 revealed to report abnormal findings to a nurse or physician/mid-level provider.</p> <p>Record review revealed Resident #1 was admitted to the facility on 06/25/14 with diagnoses of Neurogenic Bladder, Morbid Obesity, and Cardiac Dysrhythmias. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/27/14 revealed the facility assessed the resident as having an indwelling catheter. Further review of the MDS revealed the facility assessed the resident on the Brief Interview for Mental Status (BIMS) as a score of fourteen (14) out of fifteen (15) indicating the resident was cognitively intact. Further review of the record revealed Resident #1 was to receive monthly catheter changes every month per telephone order dated 07/15/14 at 10:30 AM.</p> <p>Review of Resident #1's Treatment Administration Record (TAR) for July 2014 revealed on 07/25/14 the catheter was to be changed. Further review of the TAR revealed the 25th day of July 2014 was blocked out without a signature noted.</p> <p>Interview with Resident #1, on 09/10/14 at 2:25 PM revealed his/her catheter had not been</p>	F 315	<p>2. Director of Nursing/Assistant Director of Nursing and or Nursing Unit Managers/Supervisors will review all current residents with in-dwelling catheter to determine that in-dwelling catheter were changed monthly as per physician order or as per policy, on or before October 20, 2014. Documentation to be reviewed in the residents' clinical record by Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers/Nurse Supervisors to determine if any signs/symptoms of infection are present on or before October 20, 2014.</p> <p>3. Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers/Nurse Supervisors re-educate Licensed Nurses to the policy of following physicians orders and the policy and procedures of urinary catheters to include monitoring for urinary tract infections, replacing in-dwelling catheters and documenting the change on the TAR on or before October 20, 2014. A post test will be given by the Director of Nursing and or the assistant Director of Nursing to determine competency.</p> <p>4. Director of Nursing/Assistant Director of Nursing and or Nursing Unit Managers/Nurse Supervisors will audit the progress notes and TAR of four residents with in-dwelling catheters once a week for four weeks then two residents for eight weeks to validate documentation of in-dwelling catheter change and if signs of infection are present with physician notification and on TAR to determine compliance. Corrective action will be completed at time of discovery. The results of the audit will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health</p>	

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F 315	<p>Continued From page 19</p> <p>changed since it was placed on 06/26/14 at 2:30 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 09/12/14 at 10:10 AM revealed the Foley catheter should have been changed and wasn't.</p> <p>Interview with the Director of Nursing (DON) and Unit Manager from Heritage Unit, on 09/12/14 at 10:45 AM revealed the Foley catheter should have been changed on 07/25/14 as ordered by the Physician.</p> <p>Interview with Administrator, on 09/12/14 at 12:15 PM, revealed his expectation was that staff follow physician orders.</p>	F 315	<p>Continued from page 19</p> <p>Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.</p> <p>5. Completion date: October 21, 2014</p>	10/21/14
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F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p>	F 322	<p>F322</p> <p>1. RN#2 was provided reeducation by Director of Nursing regarding the procedure for administering medication through a GT on or before October 20, 2014. Unsampled Resident A was assessed by Director of Nursing and had no negative outcome from the procedure.</p> <p>2. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse supervisors will observe Licensed Nurses administering enteral medications on or before October 20, 2014 to determine competency. Any identified concerns will be corrected.</p>	
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F 322 Continued From page 20

F 322

This REQUIREMENT is not met as evidenced by:
Based on observations, interview, and review of the facility's policy, it was determined the facility failed to ensure one (1) unsampled resident (Unsampled Resident A) received his medication administered through a Gastronomy tube (G/T) in a professionally recommended manner.

The findings include:

Review of the facility's policy, titled "Medication Administration: Enteral", effective date of 01/01/14, revision date of 01/20/14, revealed in preparing for the administration of a medication through the G/T, the nurse should prepare each medication in individual medicine cups, measure liquid medication as ordered, and crush pills and dissolve in medicine cup with 10-20 milliliters (ml) tap water. If the medication is listed as "Do Not Crush," notify the physician/mid-level provider to obtain an alternate order which may include liquid preparation of medication.

During the observation of a medication pass, on 09/10/14 at 1:00 PM, Registered Nurse (RN) #2 was observed to administer to Unsampled Resident A, Zanaflex 4.0 milligram (mg) per G/T. RN #1 was observed to crush the medication and administer the crushed medication directly into the medication syringe, without dissolving the medication in water or liquid, prior to putting the medication into the syringe. RN #2 then added water to the syringe and administered the medication per gravity flow into the G/T.

3. Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse supervisors re-educated Licensed Nurses on enteral medication administration procedure on or before October 20, 2014. A post test will be given to determine competency.

4. Director of Nursing/Assistant Director of Nursing and /or Nursing Unit Managers/Nurse Supervisors will observe two Licensed Nurses administering medication via gastronomy tube twice a week for four weeks then two Licensed Nurses once a week for eight weeks. The results of the audit will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager, Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Director of Nursing monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

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F 322 Continued From page 21

An interview with RN #2, on 09/10/14 at 1:30 PM, revealed she was taught in nursing school to dissolve the crushed medication in water prior to administering through a G/T; however, she did not know why she did not dissolve the medication in water when administering the Zanaflex 4.0 mg to Unsampld Resident A. She stated she was just nervous.

An interview with Licensed Practical Nurse (LPN) #1, on 03/11/14 at 3:50 PM, revealed when she administered a medication through a G/T, she crushed each medication into a separate cup and added a small amount of warm water to each cup prior to administering the medication through the syringe.

An interview with LPN #2, on 03/11/14 at 4:10 PM, revealed when she administered a medication through a G/T, she crushed the medication separately in a cup and dissolved the medication in water, prior to administering the medication through the G/T.

An interview with the Director of Nursing (DON), on 09/10/14 at 3:10 PM revealed it was her expectation that all of the licensed nurses followed the facility's policy for the administration of medication through a G/T and to dissolve the crushed medication in water prior to administering the medication through the G/T.

F 322

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

F 323

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

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F 323	Continued From page 22 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Material Safety Data Sheets (MSDS), Census and Condition and review of the facility's policy, the facility failed to ensure the environment remained free of accident hazards. Observation on initial tour revealed the housekeeping closet on Heritage Unit was unsecured with Quat disinfectant and hand sanitizer in closet. The Providence Unit mechanical room next to the shower room was observed unsecured during tour, which contained two (2) fuse boxes. The findings include: Review of the facility's policy titled "Storage" with a revision date of 11/07/07 revealed storage areas are locked when not in operation to prevent unauthorized access. Further review revealed information on storage of chemicals can be found in the Material Safety Data Sheet (MSDS). Review of the facility's Census and Condition dated 09/09/14 revealed of the facility's sixty-three (63) residents with Dementia, five (5) sampled resident (Residents #2, #3, #5, #6, and #15) and thirty-one (31) unsampled residents could move independently about the facility. Review of the information provided by the facility revealed the thirty-six (36) residents included unsampled residents. Review of the information provided by the facility and record review confirmed the Census and Condition information.	F 323	F323 1. The housekeeping closet door and mechanical room door were immediately secured on September 9, 2014 by housekeeping staff and Maintenance Director. 2. Director of Nursing/Assistant Director of Nursing/ Maintenance Director/ Housekeeping Director audited that storage doors and mechanical room doors were secured on September 9, 2014. No other doors were found to be unsecured. 3. Department Managers/Director of Nursing/Assistant Director of Nursing and/or Nursing Unit Managers/Nurse Supervisors re-educate the facility staff on the facility storage policy and procedure and need to ensure mechanical room and housekeeping closet doors remain locked to prevent unauthorized access on or before October 20, 2014. A post test will be given to determine competency.	

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F 323 Continued From page 23

Observation during initial tour, on 09/09/14 at 9:00 AM, revealed a Housekeeping closet door was unsecured. Further observation revealed the closet contained one (1) five (5) liter bottle of Quat disinfectant and one (1) box of Medline hand sanitizer gel.

Review of the MSDS for Quat disinfectant cleaner concentrate revealed, "may be fatal if swallowed, chemical is a corrosive causing eye and skin burns and contains ethyl alcohol and keep out of reach of children".

Review of the MSDS for Medline alcohol gel hand sanitizer revealed, "may be harmful if swallowed, causes eye irritation and contains ethyl alcohol".

Further observation, on tour on 09/09/14 at 9:55 AM, revealed the mechanical room door on Providence Unit was unsecured and contained two (2) fuse panel boxes.

Interview with Assistant Director of Nursing (ADON), on 09/09/14 at 9:05 AM revealed the unsecured doors could be a hazard to residents.

Interview with the Housekeeping Supervisor, on 09/09/14 at 9:10 AM, revealed the housekeeping closet door should be secured for the safety of the residents.

Interview with Housekeeper #1, on 09/09/14 at 10:00 AM, revealed the housekeeping closets are to be locked, so a resident can not get the chemicals.

Interview with Housekeeper #2, on 09/09/14 at 4:00 PM, revealed the housekeeping closet was

F 323

4. Administrator/Department Managers/Director of Nursing/Assistant Director of Nursing/Nursing Unit Managers to conduct an environmental audit to ensure doors are secure, daily times two weeks then three times a week for four weeks, then two times a week for four weeks and then one time a week for 4 weeks with corrective action upon discovery. The results of the audit will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Dietary, Business Office Manager, and Maintenance monthly for 3 months for further review and recommendation.

5. Completion date: October 21, 2014

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F 323	Continued From page 24 to be locked at all times, as a resident could get hold of chemicals and if the door was unlocked it would be unsafe for the residents. Interview with the Health Information Specialist, on 09/09/14 at 10:00 AM, revealed residents did not need to be around the mechanical room door and there were two (2) wanderers on this hall. Interview with the Maintenance Director, on 09/09/14 at 10:20 AM revealed he did not know if there was a policy for securing the mechanical room door. Further interview revealed the drought had caused the doors in the building not to be securing adequately. Additional interview revealed he randomly checked doors, but did not document these checks.	F 323		
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, interview, and review of facility's policy, it was determined the facility failed to prepare and store food under sanitary conditions as evidenced by hand sinks with debris, appearance of dried dust like particles on	F 371		

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F 371	<p>Continued From page 25</p> <p>Non-food contact surfaces, walls and unsafe food handling practices.</p> <p>The findings include:</p> <p>Review of the Facility Policy titled, "Thermometer Usage", with effective date 09/01/08 and revision date 04/01/14, revealed thermometers are utilized to measure food temperatures. To accurately monitor food temperatures, thermometers must be properly handled and maintained. Thermometers are washed, rinsed, sanitized and air dried before and after each use to prevent cross-contamination.</p> <p>Review of the Facility Policy titled "Handwashing", with effective date 07/01/98 and revision date 12/14/09 revealed hand washing is performed after moving from one task to another and use of disposable gloves does not replace proper hand washing.</p> <p>Review of a Health Department Inspection, dated 04/03/14 revealed a score of 89 and a revisit on 04/03/14 with a score of 94. Areas of concern noted with no change upon second visit regarding non-food contact surfaces had accumulation of soil, floors not clean, walls and ceiling were not clean.</p> <p>Review of posted Weekend Cleaning Assignments, not dated, revealed Dinner Cooks were responsible for cleaning the prep area table cabinet with pots and pans, the Robo Coupe table and behind to make sure food is off the wall, and to weep and mop before leaving. Posted cleaning assignments further revealed Breakfast Cooks were responsible for cleaning the steam</p>	F 371	<p>F371</p> <p>1. The non-food contact surfaces, walls, and hand sink were cleaned on September 9, 2014 by dietary staff. The dried gas stove burners; microwave, the cook's table cabinet, robo coupe, can opener, and drawer in food prep area were cleaned on September 9, 2014 by dietary staff.</p> <p>The wall behind the sink will be repaired on or before October 20 by Maintenance Director. The pest control company to service area on or before October 20, 2014. The dietary staff was provided re-education on appropriate cleaning of food thermometer between foods on or before October 20, 2014 by Food Service Manager.</p> <p>2. Dietician on September 24, 2014, conducted an audit using "Food Safety and Sanitation Audit" form, to identify any other cleanliness and food safety issues with corrective action if indicated.</p>	
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F 371	<p>Continued From page 26</p> <p>table, shelves under and over the table next to the steam table, and sweep and mop before leaving. Finally, review of cleaning assignments revealed the Dietary Aide was responsible for cleaning the prep table and ingredient bins underneath. The Weekend Cleaning Assignment further noted staff had all weekend to do the cleaning and it must be done and signed off.</p> <p>Observation, on 09/09/14 at 9:00 AM, during the initial kitchen tour revealed two (2) empty sanitizer buckets in a hand sink in the dish-room area, clear plastic and blue colored pitchers on an open rack. Additional observation revealed above the steam table, pans, turned upside down with dried brown running stains on the outside, the can opener on the Cook's Table with thick dried black substance at the top and along the can opener blade, the walls with the appearance of dried food particles and dust like particles on the un-labeled ingredient bins and over the tops of the spices and seasonings.</p> <p>Observation, on 09/09/14 at 11:30 AM, general kitchen tour during lunch service revealed soiled pot holder in the Cook's hand sink, un-labeled ingredient bins with dried dust like particles, microwave with appearance of dried food spatters and particles, cleaning cloth on table in front of microwave and not returned to sanitizer bucket or put into soiled linen bin, and gas stove burners with dried black substance built up around the burners.</p> <p>Observation, on 09/09/14 at 11:45 AM, of the resident lunch tray line revealed Diet Aide/Cook #1 dropped the food thermometer onto the floor, picked the thermometer up and put it under running water in the hand sink and dried off with a</p>	F 371	<p>3. Administrator/Food Service Manager re-educated the dietary staff to the facility policy on cleaning and disinfecting food service area, handwashing and glove usage, and cleaning/use of kitchen thermometers on or before October 20, 2014. A post test will be given to determine competency.</p> <p>4. Administrator/Food Service Manager/Registered Dietician/Department Managers to audit kitchen sanitation including handwashing and glove usage and thermometer practices to determine compliance four times a week across all meal service for four weeks then three times a week for four weeks, then two times a week for four weeks with corrective action upon discovery. A summary of the audit findings will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, by the Food Service manager monthly for 3 months for further review and recommendation.</p> <p>5. Completion date: October 21, 2014</p>	10/21/14

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F 371	<p>Continued From page 27</p> <p>paper towel. Diet Aide/Cook #1 proceeded as if to put the food thermometer into the turkey on the resident tray line and was stopped by the surveyor.</p> <p>Interview, on 09/09/14 at 11:45 AM, with Diet Aide/Cook #1 revealed she always just washed off the thermometer with hot water and used a paper towel to wipe the thermometer. She further revealed she had not been trained how to use the wipes to clean the thermometers.</p> <p>Observation, on 09/09/14 at 11:55 AM, revealed eight (8) half steam table pans and two (2) full steam table pans, from the pot and pan sink, stacked together, wet and dripping with water were placed onto the open rack. Three (3) flies were observed flying over the Cook's table and landing on the utensils hanging on the Cook's Rack. The Cooks Table Cabinet had the appearance of dried dust like food particles in the open cabinet, and the drawer in the prep table, and under the Robo Coupe (Food Processor) contained dried dust like food particles.</p> <p>Observation, on 09/10/14 at 1:55 PM, of the dish-room area revealed broken wall area around hand sink, un-labeled ingredient bins with dust like particles and five (5) flies noted above the kitchen area, landing on utensils on Cook's Rack over chopped lettuce on the cutting board unattended.</p> <p>Interview, on 09/10/14 at 2:10 PM, with Diet Aide/Cook #2 revealed hands should be washed between tasks, after using the restroom, preparing meats, changing gloves and handling dirty dishes. The thermometer should be cleaned with wipes and had not been instructed on how to</p>	F 371			

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F 371	<p>Continued From page 28</p> <p>sanitize the thermometer. He further revealed the deep cleaning was done over the weekend and the cleaning was not documented. Pans should be air dried before they were put up and if still wet when stacked they needed to be re-washed. The cleaning clothes should be stored in the sanitizer bucket and should be changed four (4) to five (5) times per day.</p> <p>Interview, on 09/10/14 at 2:35 PM, with Cook/Interim Dietary Manager revealed hands should be washed between new tasks because of the possibility of cross contamination. The thermometer should be rinsed off under water and wiped dry with a paper towel. She further revealed this was how she has always cleaned the thermometer. She stated there was no documentation of the daily cleaning and she encouraged staff to clean as they go. The Weekend Cleaning Assignments were posted and deep cleaning was done on the weekend by staff. There was no documentation of the cleaning that was done on the weekends. There could be contamination if cleaning was not done. There should be no trash or sanitizer buckets in the hand sink to prevent cross contamination. All pans should be placed upside down and allowed to air dry before they were stacked. All cleaning cloths should be kept in the sanitizer bucket.</p> <p>Interview, on 09/10/14 at 3:45 PM, Maintenance Director revealed the wall by the hand sink had been repaired in the past and he needed to take the sink out and re-do the whole wall. He further revealed he did not remember the Cook/Interim Dietary Manager talking to him about the wall and did not have a work order.</p> <p>Interview, on 09/11/14 at 10:30 AM, Diet</p>	F 371		

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F 371	<p>Continued From page 29</p> <p>Aide/Cook #3, revealed hands should be washed between tasks glove changes, after touching meats and entering the kitchen. The thermometer should be cleaned and sanitized with wipes between foods.</p> <p>Interview, 09/12/14 at 10:25 AM, Cook/Interim Dietary Manager revealed she did not know about pest control but would contact maintenance man to call the pest people. She further revealed she believed the pest control company was ECO-Labs.</p> <p>Interview, 09/12/14 at 5:30 PM, with the Administrator revealed his expectations of the Dietary Department was to serve nutritious meals and to follow the policies/procedures for cleanliness. The Cook/Interim Dietary Manager, Administrator and the Corporate Manager oversee and were responsible for the Dietary Department.</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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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
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1986, 1996 Survey under: 2000 Existing (Short Form) Facility type: SNF/NF Type of structure: One (1) story Type V(111) with partial basement Smoke Compartments: four (4) Fire Alarm: Full fire alarm system installed in 1986 Sprinkler System: Automatic (dry) sprinkler system installed in 1986 Generator, Type II natural gas installed in 2001 A Standard Life Safety Code Survey was initiated and concluded on 09/10/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 10/8/14

A 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 038	<p>Continued From page 1 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain an exit and exit access in accordance with National Fire Protection Agency standards. This deficient practice affected one (1) of four (4) smoke compartments, staff and approximately seventeen (17) residents. The facility has the capacity for 95 beds with a census of 93 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 09/10/14, at 11:00 AM, with the Director of Maintenance (DOM), a double exit door leading from the front entrance of the facility was observed to have time delayed magnetic locks. There was no signage on the door on how to release the magnetic door locks in order to leave the facility in an emergency situation as required.</p> <p>An interview with the DOM on 09/10/14, at 11:00 AM revealed he was aware the doors required this type of signage; however, he was not aware how long the signage had been missing.</p> <p>The findings were revealed to the Administrator on exit.</p>	K 038	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Grant 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."</p> <p>K038</p> <ol style="list-style-type: none"> 1. Signage in accordance of NFPA 101 200 edition 7.2.1.6.1 was placed on door on September 15, 2014. 2. All like doors in facility were checked for proper signage on or before October 20, 2014. 3. Administrator/Corporate Property Manager re-educated Maintenance Director on NFPA 101 200 edition 7.2.1.6.1. A post test was given to determine competency on or before October 20, 2014.

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K 038	Continued From page 2 Reference: NFPA 101 2000 edition 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30	K 038	4. Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director, Assistant Director of Nursing, Payroll/HR Manager, Nursing Unit Managers will conduct an environmental audit three times a week for four weeks, then two times a week for four weeks and then one time a week for 4 weeks. Audit results will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director monthly for 3 months for further review and recommendation. 5. Completion date: October 21, 2014	10/21/14

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K 038	Continued From page 3 seconds shall be permitted.	K 038		
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 95 beds with a census of 93 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/10/14 at 1:05 PM an interview and record review with the Director of Maintenance (DOM), revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first and third shifts as follows:</p> <p>Three (3) fire drills on the first shift from 03/28/14 thru 06/27/14 were conducted between 1:30 PM</p>	<p>K 050</p> <p>K050</p> <ol style="list-style-type: none"> 1. Fire drills conducted during fourth quarter beginning in October on or before October 20, 2014 will be held at unexpected times under varying conditions. 2. Administrator/Corporate Property Manager re-educated Maintenance Director on conducting fire drills at unexpected times and under varying conditions on or before October 20, 2014. A post test was given to determine competency on or before October 20, 2014. 3. Administrator/ Corporate Property Manager audit fire drill documentation once a month to determine fire drills are being conducted at varying times under varying conditions for 3 months. Audit results will be submitted to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Dietary, Business Office Manager, and Maintenance Director, by the Administrator for further review and recommendation. 4. Completion date: October 21, 2014 	10/21/14	

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K 050	Continued From page 4 and 2:05 PM. Three (3) fire drills on the third shift from 04/28/14 thru 7/10/14 were conducted between 6:00 AM and 6:35 AM. The DOM stated he was not aware fire drills should be conducted at unexpected times and under varying conditions. The findings were revealed to the Administrator on exit.	K 050		