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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

(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 Recertification Survey was initiated on 06/23/15 and concluded on 06/26/15, with deficiences cited at the highest Scope and Severity of a "G".	F 000		
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 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 each resident's Comprehensive Care Plan was reviewed and revised for two (2) of eighteen (18) sampled residents (Resident #8	F 280	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. RECEIVED JUL 22 2015	

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

Administrator 7/22/15

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 280	Continued From page 1 and Resident #14). Resident #8 was assessed by the facility to be at risk for falls and the resident was care planned to ask for assistance when getting up, and to have a reacher provided to assist with picking things up. Interviews with staff revealed Resident #8 continuously got up without asking for assistance and was frequently non-compliant with using call light. Resident #8 experienced thirteen (13) falls from 01/15/15 to 06/15/15, requiring two (2) staples to his/her forehead as a result of the fall on 01/15/15, and eight sutures to his/her forehead as a result of a fall on 03/13/15. However, there was no documented evidence the care plan interventions were evaluated and revised with appropriate interventions to prevent falls. Resident #14 was assessed as at risk for falls and care planned for the risk with interventions which included two (2) staff assist with Activities of Daily Living (ADLs). However, record review revealed Resident #14 was a Hospice resident and the resident was bedbound, with no documented evidence the Comprehensive Care Plan was revised to include the information. The findings include: Review of the facility's policy titled, "Care Plans", revised 01/02/14, revealed a comprehensive, individualized care plan would be developed by the interdisciplinary team (IDT) for each resident. Per the Policy, the Care Plan was to include measurable objectives to meet a resident's needs and goals as identified by the assessment process. Additional review of the Policy revealed its purpose was to provide necessary care and	F 280	F-280-D 1. Resident #8's comprehensive fall care plan was reviewed by the Director of Nursing to ensure there was documented evidence the care plan interventions were evaluated and revised with appropriate interventions to prevent falls by 8/3/15. Resident #14 no longer is in the facility. All residents have the potential to be affected. 2. All residents' fall comprehensive care plans will be reviewed and revised with appropriate interventions to prevent falls by the Director of Nursing, Assistant Director of Nursing, Unit Manager's, or Weekend Supervisor by 8/3/15. Any corrections will be implemented as needed.	

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F 280	Continued From page 2 services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being. Further review revealed the Care Plan was to reviewed and revised at least quarterly, and as needed, to reflect a resident's response to care and changing needs and goals. Review of the facility's, "Falls Care Delivery Process", revised 06/01/13, revealed after a fall staff were to update the resident's Care Plan with a new intervention, as appropriate. Continued review revealed staff were to monitor the resident's response to the intervention to determine if the intervention was successful. Per the Process, monitoring was to be achieved through consistent observation, documentation, and review. Additional review of the facility's "Falls Care Delivery Process" revealed the Care Plan should be re-evaluated regularly for appropriate falls risk interventions to assure correlation of interventions with any investigative findings for a resident who experienced a fall. 1. Record review revealed the facility admitted Resident #8 on 04/16/12, with diagnoses which included Alcoholic Cirrhosis of the Liver, Altered Mental Status, Retention of Urine, Generalized Pain, Anxiety and Depression. Review of the Annual Minimum Data Set (MDS) assessment dated 01/30/15, revealed the facility assessed Resident #8 to be cognitively intact, with a Brief Interview Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact and interviewable. Further review revealed the facility assessed Resident #8's transfer and ambulation abilities as independent with no set up or physical help required.	F 280	3. Nurses will be re-educated on immediate evaluation and revision of fall interventions and care plan updates as indicated by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor by 8/3/15. A post-test will be given to all nurses by 8/3/15 to validate understanding. Nurses not available during this time frame will receive re-education including posttest by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor upon return to work. The Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, Weekend Supervisor or licensed nurses will audit each fall daily across all shifts to validate that the fall intervention care plan is evaluated and revised as indicated x 2 weeks, then 3x/week across all shifts x 2 weeks, then as determined by the monthly Quality Improvement Committee with corrective action if indicated. Any area of concern will be corrected when identified.	

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F 280	Continued From page 3 Review of the Comprehensive Care Plan, dated 06/27/14, the most current care plan at the time of the fall on 01/15/15, revealed Resident #8 was at risk for falls with a goal stating the resident would not sustain any injuries related to falls. Further review revealed interventions to keep clutter from walking areas, encourage Resident #8 to ask for assistance when getting out of bed, and provide a rescher to assist with picking up things off the floor. Review of the facility's Falls Investigation Report, dated 01/15/15 at 6:00 AM, revealed Resident #8 had experienced an unwitnessed fall in his/her room. Per the Report, Resident #8 sustained a laceration to the forehead, and a skin tear to the left knee and left wrist. Continued review revealed the Physician was notified and Resident #8 was sent to the Emergency Department (ED) to be evaluated. Further review revealed the facility determined the cause of the fall as, "Resident bending over to reach for a thing", and the corrective action to prevent further falls included Physical Therapy to screen, staples to his/her head, and staff to observe for signs and symptoms of infection. However, there was no documented evidence the facility evaluated or revised interventions on the Care Plan to prevent further falls. Review of a hospital ED Note, dated 01/15/15, revealed Resident #8 was evaluated for a fall with injury to his/her head. Resident #8 was noted to have a laceration which measured three (3) centimeters (cm). Further review revealed the resident required a laceration repair and received two (2) staples to close the injury.	F 280	4. The Director of Nursing and/or Assistance Director of Nursing will submit a summary of the finding of the audits to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director monthly for three months for any additional follow up and/or in-servicing needs. 5.) Completion date: August 4, 2015.	8/04/15

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F 280	Continued From page 4	F 280		

Continued record review revealed Resident #8 continued to experience falls after 01/15/15, sustaining four (4) additional falls from 02/02/15 to 03/13/15 at 9:00 AM. Continued review of the facility's Fall Investigation Reports revealed Resident #8 experienced falls on: 02/02/15 at 10:00 PM with skin tears obtained to the resident's left elbow and right forearm; 03/04/15 at 8:00 PM no injury noted; on 03/04/15 at 9:25 PM with no injury noted; and on 03/13/15 at 9:00 AM, with skin tears to the right forearm and right lower leg.

Further review of the facility's Fall Investigation Reports of a Report dated 03/13/15 at 3:15 PM, revealed Resident #8 was found by staff lying on the floor in his/her room, and the resident was assessed to have a two (2) inch laceration to the forehead and a skin tear to the wrist. Per the Report, Resident #8 stated he/she bent forward to get batteries for a remote control out of a drawer and fell forward. The Report revealed Resident #8 had pain to his/her forehead, the Physician was notified and the resident was sent to the ED for evaluation. Further review revealed the corrective actions stated Resident #8 received eight (8) sutures to his/her head in the ED and a pressure alarm was added to the resident's bed to alert staff of unassisted transfers.

Review of a hospital ED note, dated 03/13/15, revealed Resident #8 was assessed to have a five (5) centimeter (cm) laceration and required laceration repair with eight (8) sutures to his/her head.

Further record review revealed Resident #8 sustained seven (7) additional falls from 03/19/15

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F 280	Continued From page 5	F 280		

through 06/15/15 with no significant injuries noted. However, continued review of Resident #8's Comprehensive Care Plan revealed no documented evidence the facility revised the resident's at risk for falls care plan to initiate additional and appropriate interventions as necessary to prevent further falls, such as, offering to assist the resident to the toilet frequently and keeping items in reach.

Interview with Resident #8, on 06/26/15 at 3:52 PM, revealed the resident did not know what caused his/her frequent falls. Resident #8 reported using the call light to get staff when assistance was needed.

Interview with Certified Nursing Assistant (CNA) #1, on 06/25/15 at 5:05 PM, revealed Resident #8 was easily confused, especially at night, and was not compliant with using the call light and asking for assistance.

Interview with CNA #2, on 06/25/15 at 5:10 PM, revealed Resident #8 would frequently get up without asking for assistance.

Interview with Licensed Practical Nurse (LPN) #1, on 06/26/15 at 3:43 PM, revealed she was on duty on 01/15/15 and was the nurse for Resident #8. She stated Resident #8 sustained a fall and she was sent out to the ED. She further stated she did not update the Care Plan because the resident went to the ED. Continued interview with LPN #1 revealed Resident #8 was frequently non-complaint with using the call light and asking for assistance before getting up. Further interview revealed she believed the interventions placed to prevent falls for Resident #8 had been ineffective; she stated nothing had been effective

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F 280	Continued From page 6	F 280		

so far.

Interview with LPN #2, on 06/25/15 at 5:23 PM, revealed Resident #8 was extremely independent and often got up without asking for assistance.

Interview with the Unit Manager/RN #1, on 06/25/15 at 6:35 PM, revealed Resident #8 was not compliant with using the call light and requesting assistance. She stated Resident #8 had elevated ammonia levels which fluctuate during the day and cause confusion. She stated the nurse on duty at the time of a fall was responsible for updating the Care Plan.

Interview with the Director of Nursing (DON), on 06/26/15 at 2:10 PM, revealed Resident #8 was non-compliant with using the call light when needing assistance. She stated the resident also had frequent episodes of confusion due to fluctuating levels of ammonia. The DON further stated the facility would never be able to prevent the Resident #8's falls and the resident would fall again. Continued interview revealed it was the DON's expectation for the nursing staff to evaluate the effectiveness of the Care Plan interventions and place appropriate new interventions to prevent further falls.

2. Review of the clinical record revealed Resident #14 was admitted by the facility on 06/09/15 with diagnoses which included End-Stage Liver Disease, Anemia, Depressive Disorder, Generalized Pain, and Hepatitis C.

Review of the Admission MDS Assessment, dated 06/16/15, revealed the facility assessed Resident #14 to be moderately cognitively impaired, was unable to ambulate and required

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F 280	Continued From page 7	F 280		

two (2) person extensive staff assistance for Activities of Daily Living (ADLs). Continued review of the MDS revealed Resident #14 was assessed to have altered consciousness, inattention and disorganized thinking.

Review of the Nurse Aide Care Card, dated 06/10/15, revealed Resident #14 was dependent for all care and was a two (2) person assist.

Review of the Hospice care plan for Resident #14, dated 06/10/15, revealed the resident was bedbound, forgot limitations, and was at risk for falls. Continued review revealed the resident was lethargic and stuporous at times, and exhibited agitation and restlessness.

Review of the Comprehensive Care Plan revealed Resident #14 was at risk for falls and required two nursing staff (2) to provide extensive assistance with ADLs. Further review of the Care Plan revealed the resident's condition was terminal and he/she received Hospice services.

Review of the Risk Management System report, dated 06/15/15, revealed Resident #14 fell while being lifted out of the tub with a mechanical lift. Continued review revealed the seat of the bath chair was wet, causing the resident to slide out of the bath chair. Two (2) nursing staff were unable to stop the resident from sliding out of the chair. The report stated the seat belt was replaced due to blood from the resident being on the seat belt; however, there was no evidence to indicate the seat belt was in use when the resident fell.

Further review of Resident #14's Comprehensive Care Plan revealed the facility revised it on 06/15/15 with an intervention for bed baths to be

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F 280	Continued From page 8	F 280		

provided in the future; however, the Care Plan was not revised to indicate the resident's bedbound status as recommended by Hospice, even though the resident continued to require psychotropic and pain medications, was weakened and in a terminal state, and had episodes of lethargy and stuporous levels of consciousness.

Observation of Resident #14, on 06/25/15 at 11:10 AM, 11:55 AM, 3:20 PM and 4:12 PM, revealed the resident in bed with eyes closed. The resident was noted to barely move his/her extremities and to lie quietly in bed. The resident's skin was yellowish in color and a large abdominal girth was noted.

Interview with Resident #14, on 06/25/15 at 11:10 AM, revealed the resident's voice was low and speech was mumbled. The resident was confused and responses were not understood.

Interview with CNA #1, on 06/25/15 at 5:01 PM, revealed she was responsible for bathing Resident #14 on 06/15/15. She stated the resident had no trunk control and was not able to sit up straight on the tub chair and slid off the chair hitting the tub with injuries to the head, right knee, and right arm. She further stated the resident was too sick to be up in a chair.

Interview with LPN #1, on 06/25/15 at 5:32 PM, revealed Resident #14 did not have good trunk control and had weakness which prevented the resident from sitting up in a chair. She stated she revised the Care Plan after the resident's fall in the tub to include bed baths; however, she did not review or revise other care plan interventions which directed the resident be out of bed to

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F 280	Continued From page 9 attend group activities or use the Hoyer lift to get the resident up. She stated she had been trained on writing care plans and updated the plans as needed. Interview with the Assistant Director of Nursing (ADON), on 06/26/15 at 11:17 AM, revealed all resident Care Plans started with the problem of, at risk for falls and should be revised if needed. She acknowledged Resident #14 was too sick to get out of bed for a bath. Interview with the DON, on 06/26/15 at 2:09 PM, revealed she was familiar with the hospice care plan and this care plan would be added as needed.	F 280		
F 282 SS=D	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 facility policy review, it was determined the facility failed to ensure two (2) of eighteen (18) sampled residents care plan interventions were followed (Residents #14 and #9). Resident #14 had an intervention for a trapeze bar to assist the resident with bed mobility. Resident #9 had an intervention for a seat lifting chair with a remote control device. The findings include:	F 282		

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F 282	Continued From page 10	F 282		

Review of the facility's, Care Plan policy, dated 01/02/14, revealed the purpose was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being.

Interview with the Director of Nursing (DON), on 06/26/15 at 2:10 PM, revealed the facility did not have a policy specific to staff implementing residents' care plan intervention; however, the expectation was staff would do so.

1. Review of the clinical record for Resident #14, revealed the resident was admitted by the facility with diagnoses of Adult Failure to Thrive, Dysphasia, Urinary Retention, Atrial Fibrillation, Contractures of Both Legs and Depression.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/01/15, revealed the facility assessed Resident #14 as alert and oriented, to require extensive assistance with his/her Activities of Daily Living (ADLs) and to be totally dependent on staff to transfer out of the bed with the use of a trapeze bar for movement from side to side in bed.

Review of the Comprehensive Care Plan, initiated on 09/22/14, for Resident #14, revealed the resident required a trapeze bar to the bed to assist with bed mobility which was initiated on 04/14/14.

Observations of Resident #14, on 06/23/15 at 11:26 AM, 2:06 PM, 2:53 PM, 3:29 PM, and 4:23 PM, and on 06/24/15 at 9:06 PM, revealed the resident's trapeze bar was in place to his/her bed; however, the hand hold was flipped up over the

F-282-D

1. Resident #14 no longer resides in the facility.

The Director of Nursing conducted observation rounds of resident #9 on 7/1/15 to ensure care plan interventions were followed with corrective action as indicated.

2. All residents have the potential to be affected. Observation rounds will be conducted of all residents by Director of Nursing, Assistant Director of Nursing, Unit Manager's, or Weekend Supervisor by 8/3/15 to ensure care plan interventions are followed. Any corrections will be implemented as needed.

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F 282	Continued From page 11 trapeze bar out of the resident's reach. Observations revealed the resident was noted to be trying to reach the trapeze bar on 06/23/15 at 11:26 AM and 2:53 PM, and on 06/24/15 at 9:06 AM. Interview with Resident #14, on 06/23/15 at 2:53 PM, revealed the resident had contractures of both legs and needed assistance to move about in the bed, and that's why he/she had the trapeze bar. Resident #14 stated he/she often could not reach the trapeze bar hand hold as nursing staff flipped the hand hold up and over the trapeze bar out of his/her reach. Per interview, the trapeze bar assisted him/her with being able to pull up in bed or move from side to side. The resident revealed he/she would like the bar to be available for use at all times. Interview with Certified Nursing Assistant (CNA) #1, on 06/25/15 at 5:01 PM, revealed Resident #14's trapeze bar hand hold was flipped up out of the resident's reach to prevent the resident from hitting his/her head on the bar. She stated she knew Resident #14 could not reach the hand hold when it was flipped up over the trapeze bar; however, she only lowered the hand hold when she assisted the resident to turn in bed, otherwise it was left out of reach. Per interview, the hand hold should be in reach of the resident though. Interview with Licensed Practical Nurse (LPN) #1, on 06/25/15 at 5:32 PM, revealed Resident #14's care plan interventions were to be followed by staff. She stated Resident #14 needed the trapeze bar to promote movement in bed. 2. Review of the clinical record for Resident #9, revealed the facility admitted the resident, on	F 282	3. Nurses will be re-educated the by Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor on to ensure care plan interventions are followed by 8/3/15. A post-test will be given to all nurses by 8/3/15 to validate understanding. Nurses not available during this time frame will receive re-education including posttest by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor upon return to work. Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, Weekend Supervisor, or Licensed Nurses will conduct observation rounds daily across all shifts to validate that the care plan interventions are followed x 2 weeks, then 3x/week across all shifts x 2 weeks, then as determined by the monthly Quality Improvement Committee with corrective action if indicated. Any area of concern will be corrected when identified.	

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. BUILDING _____ B. WING _____	06/26/2015

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F 282	Continued From page 12 10/08/14 with diagnoses of Alzheimer's Disease, Diabetes, Depression, Irritable Bowel Syndrome and Aphasia.	F 282		

Review of the Quarterly MDS Assessment, dated 04/16/15, revealed the facility assessed Resident #9 as severely cognitively impaired and to require extensive assistance with all ADLs. Further review revealed the facility assessed Resident #9 as non-ambulatory and incontinent.

Review of the Resident #9's Comprehensive Care Plan, initiated on 10/07/14 and revised on 04/16/15, of the risk for falls care plan revealed the resident had impaired mobility, cognitive loss, lack of safety awareness and a history of falls. Continued review revealed Resident #9's care plan was revised with an intervention, dated 02/03/15, to keep the recliner remote control out of the resident's reach when he/she was in the recliner. However, observations revealed Resident #9's recliner remote control was attached to the recliner and accessible to the resident.

Review of the Risk Management System record for Resident #9, dated 02/03/15, revealed Resident #9 raised the recliner seat up to a standing position using the recliner remote control and slid out of the recliner to the floor without injury.

Review of the Risk Management System record for Resident #9, dated 05/22/15, revealed Resident #9 slid out of the recliner after using the recliner remote control to lift the seat up into a standing position, with no injury noted.

Interview with CNA #1, on 06/25/15 at 5:01 PM,

4. The Director of Nursing and/or Assistance Director of Nursing will submit a summary of the findings to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director monthly for any additional follow up and/or in-servicing needs for three months. 8/04/15

5. Completion date: August 4, 2015

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

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OMB NO. 0938-0391

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F 282	Continued From page 13 revealed Resident #9 was able to reach the recliner remote control and use it to lift the chair up to a standing position. She stated the remote was supposed to be hidden from the resident's view. She stated she did not know how the remote control came to be in Resident #9's possession. Interview with LPN #1, on 06/25/15 at 5:32 PM, revealed Resident #9 was able to reach the remote related to the remote control being attached to the chair. LPN #1 revealed she could not explain how Resident #9's recliner remote control was to be concealed from the resident. However, she stated the care plan clearly reflected the remote control was to be kept out of view of the resident.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT 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 and procedures, it was determined the facility failed to ensure three (3) of eighteen (18) sampled residents (Residents #8, #9, and #14) had environmental hazards and risk factors for falls identified and interventions, including supervision, put into place	F 323		

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

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F 323	Continued From page 14 to reduce falls. In addition, the facility failed to determine the causal factors for falls and monitor interventions for effectiveness which resulted in Residents #8, #9 and #14 sustaining additional falls. The findings include: Review of the facility's policy and procedure titled, "Falls Management", revised 05/15/14, revealed the facility's policy was to assess residents for falls risk as part of the nursing assessment process. Residents determined to be at risk will receive appropriate interventions to reduce the risk of falls and minimize injury. Further review revealed its purpose was to reduce the risk for falls and minimize the actual occurrence of falls. Additionally, residents experiencing a fall will receive appropriate care and investigation of the cause. 1. Record review revealed the facility admitted Resident #8 on 04/16/12 with diagnoses to include Alcoholic Cirrhosis of the Liver, Altered Mental Status, Retention of Urine, Generalized Pain, Anxiety and Depression. Review of an annual Minimum Data Set (MDS) assessment dated 01/30/15, revealed the facility had assessed Resident #8's cognition as intact with a Brief Interview Mental Status Score of fifteen (15) indicating the resident was interviewable. Further review revealed the facility had assessed Resident#8's transfer and ambulation as independent with no set up or physical help required. Review of a Comprehensive Care Plan dated	F 323	**F-323-D** 1. Resident #8 and #9's fall history was reviewed from 5/6/15 to 7/17/15 to validate fall causal factors are identified and interventions to monitor effectiveness are in place by Director of Nursing and Assistant Director of Nursing by 8/3/15. Resident #14 no longer resides in the facility. 2. All residents have the potential to be affected. All residents that have had a fall from 5/6/15 to 7/17/15 were reviewed and observed by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor to validate fall causal factors were identified and interventions to monitor effectiveness are in place by 8/3/15.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 15 06/27/14 , revealed Resident #8 was at risk for falls with a goal that the resident would not sustain any injuries related to falls. Further review revealed interventions to keep clutter from walking areas, encourage Resident #8 to ask for assistance when getting out of bed and provide reacher to assist with picking up things off the floor. Review of a facility Falls Investigation Report dated 01/15/15 at 6:00 AM, revealed Resident #8 was found lying on the floor in his/her room next to his/her bed. Further review of the falls investigation report revealed Resident #8 stated he/she fell picking up something from the floor and hit his/her head on an oxygen concentrator. Additional review of the falls investigation revealed Resident #8 was assessed at that time to be bleeding and had a skin tear on his/her left knee and left wrist. An ambulance was called and the resident was taken to the local Emergency Department (ED) where the resident received two (2) staples to the forehead. Continued review of the Falls Investigation Report revealed environmental factors identified at the time of the fall included personal items not within easy reach. Review of a Nurse's Note dated 01/15/15 at 10:58 AM, revealed Resident #8 returned from the ED and received two (2) staples to his/her forehead. Additional review revealed Resident #8 was noted to have bruising to left forehead and a skin tear which measured 1.0 Centimeters (cm) by 0.7 cm to his/her left outer wrist and dark purple bruising noted to his/her right hip. Review of the facility's Falls Investigation Report, Summary of Investigation, completed on	F 323	3. Nursing staff will be re-educated on accident/fall prevention to ensure that fall causal factors are identified and interventions to monitor effectiveness are in place by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor by 8/3/15. A posttest will be given to all nursing staff by 8/3/15 to validate understanding. Nurses not available during this time frame will receive re-education including posttest by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor upon return to work. Any fall will be reviewed by Director of Nursing, Assistant Director of Nursing, Unit Managers, 3-11 Supervisor, 11-7 Supervisor, Weekend Supervisor, or Licensed Nurses to verify that fall causal factors were identified and interventions to monitor effectiveness daily across all shifts x 2 weeks, then 3x/week across all shifts x 2 weeks, then as determined by the monthly Quality Improvement Committee with corrective action if indicated. Any area of concern will be corrected when identified.	

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F 323	Continued From page 16 01/16/15, revealed the root cause of the fall was determined to be "Resident bending over to reach for things". Corrective actions to prevent further falls included Physical Therapy to Screen and staples to head, and staff to observe for signs and symptoms of infection. However, there was no documented evidence the facility identified the root cause of the fall or placed appropriate interventions in place to prevent further falls. Interview with Licensed Practical Nurse (LPN) #1, on 06/26/15 at 3:43 PM, revealed she was on duty on 01/15/15 and was the nurse for Resident #8. She stated Resident #8 had a fall and she was sent out to the ED. She stated she determined the root cause of the fall was due to Resident #8 bending over to pick something up off the floor. She stated she believed the interventions placed to prevent falls have been ineffective and stated nothing has been effective so far. Review of a facility Falls Investigation Report dated 02/02/15, at 10:00 PM, revealed Resident #8 was found lying on the floor. Further review revealed Resident #8 had fallen onto his/her bedside table and broke it. Resident #8 was assessed to have a skin tear to his/her left elbow and a skin tear to his/her right forearm. Continued review revealed the root cause of the fall was determined to be poor safety awareness, resident was reaching for items on bedside table and fell while standing up to reach (items). Corrective actions to prevent further falls included a bed alarm related to the resident's cognition occasionally varies and Physical Therapy to screen. Record review revealed Resident #8 had three	F 323	4. The Director of Nursing and/or Assistance Director of Nursing will submit a summary of the finding of the audits to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director monthly for any additional follow up and/or in-servicing needs for three months. 5. Completion date: August 4, 2015	8/04/15

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

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F 323	Continued From page 17 (3) additional falls from 03/04/15 to 03/14/15. Resident #8 fell 03/04/15 at 8:00 PM and on 03/04/15 at 9:25 PM and on 03/13/15 at 9:00 AM with no significant injuries noted. Review of the facility's Fall Investigation Report dated 03/13/15 at 3:15 PM, revealed Resident #8 was found on the floor in his/her room. Resident #8 was noted to be bleeding and was assessed to have a two (2) inch laceration to his/her forehead. Additional review revealed Resident #8 was noted to have a small skin tear to his/her left wrist. Further review revealed Resident #8 stated he/she was bent forward trying to get batteries for a remote control out of a drawer and fell forward. Further review revealed an ambulance was called and Resident #8 was taken to the ED. Further review of the Falls Investigation revealed no documented evidence the facility identified the root cause of the fall. Additionally, there was no documented evidence the facility evaluated the interventions that were in place to ensure effectiveness or evaluated if new interventions were required. Review of an ED note dated 03/13/15, revealed Resident #8 was assessed to have a five (5) centimeter (cm) laceration and required laceration repair with eight (8) sutures. Record review revealed Resident #8 continued to have seven (7) additional falls from 03/19/15 through 06/15/15 with no significant injuries noted. Interview with Resident #8 on 06/26/15 at 3:52 PM, revealed she did not know what caused her frequent falls and stated she used her call light when she needed assistance; however, she	F 323		

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F 323	Continued From page 18	F 323		

stated it sometimes took the nurses and aides a long time to answer.

Interview with the Unit Manager RN #1, on 06/25/15 at 6:35 PM, revealed Resident #8 was not compliant with using the call light. She stated Resident #8 had elevated ammonia levels which fluctuate during the day which caused confusion. She stated the nurse on duty at the time of the fall completed the Investigation Report and then the Director of Nursing, Assistant Director of Nursing (ADON) and Unit Managers do investigation along with the direct care staff.

Interview with the Assistant Director of Nursing (ADON) on 06/26/15 at 11:20 AM, revealed it was the nurse on duty at the time of the fall to complete the Falls Investigation Report. She further stated this was not really an investigation, the nurses just put what they think happened. She further stated the investigation should be conducted to determine the root cause to place an appropriate intervention to prevent further falls.

Interview with the Director of Nursing (DON) on 06/26/15 at 2:10 PM, revealed Resident #8 was non-compliant with using the call light when he/she needed assistance. She stated the resident also had frequent episodes of confusion due to her fluctuating levels of ammonia. The DON stated the facility would never be able to prevent Resident #8's falls and he/she would fall again.

2. Review of the medical record for Resident #14, revealed the facility admitted the resident on 06/09/15 with diagnoses of End-Stage Cirrhosis of the Liver, Hepatitis C, Depressive Disorder,

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

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F 323	Continued From page 19 Anemia and Deep Vein Thrombosis of the Right Arm. Hospice care was initiated on 06/10/15 for Resident #14, who had a terminal diagnosis. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/16/15, for Resident #14, revealed the resident was moderately impaired cognitively and required extensive assistance with activities of daily living, including two (2) for bathing. The resident was incontinent of bowel and had an indwelling catheter. The resident had altered consciousness, inattention, and disorganized thinking. In addition, the resident received psychotropic medication. Review of the comprehensive care plan for Resident #14, initiated by the facility on 06/10/15, revealed the resident was at high risk for falls and needed extensive assistance of two (2) with bathing. The care plan did not address the resident's weakness and how staff was to manage the resident when out of bed (geri-chair, wheelchair). Review of the Hospice care plan for Resident #14, dated 06/10/15, revealed the resident forgot limitations, was bedbound and was at risk for falls. The resident was lethargic and stuporous at times and had agitation and restlessness. Review of the Risk Management System report, dated 06/15/15, revealed Resident #14 was taken from bed, by the Hospice aide and the facility's aide, to the shower room and sustained a fall at 10:30 AM. The Hospice care plan revealed the resident was bedbound. The resident was placed in the bath chair and mechanically lifted into the tub. When the bath was completed, the chair was being lifted mechanically out of the tub when	F 323		

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F 323	Continued From page 20	F 323		

the resident slipped out of the chair and landed on both knees. The resident hit the right side of his/her face on the rim of the tub. The resident complained of pain all over, especially in the right leg and foot, and had bruising to the right side of the face and the right knee. In addition, the resident sustained two (2) skin tears on the right arm. The facility listed fall prevention was in place, the Hospice aide, at the time of the fall.

Further review of the Risk Management System report, revealed the root cause of Resident #14's fall was caused by the wet seat in the tub causing the resident to slide out of the bath chair. Two (2) nursing staff were unable to stop the resident from sliding out of the chair. There was no evidence that the facility used the chair seat belt while the resident received the bath. The report stated the seat belt was replaced related to blood from the resident being on the seat belt.

Further review of the care plan for Resident #14, dated 06/10/15, revealed nursing staff was to use two (2) persons and a Hoyer mechanical lift to transfer the resident out of bed; however, the Hospice care plan stated the resident was bedbound.

Observation of Resident #14, on 06/25/15 at 11:10 AM, 11:55 AM, 3:20 PM and 4:12 PM, revealed the resident in bed with eyes closed. The resident was noted to barely move his/her extremities and laid quietly in bed. The resident was yellowish in color and had a large abdominal girth.

Interview with Resident #14, on 06/25/15 at 11:10 AM, revealed the resident's voice was low and speech was mumbled. The resident was

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

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F 323	Continued From page 21 confused and responses were not understood. Interview with Certified Nursing Assistant (CNA) #1, on 06/25/15 at 5:01 PM, revealed she was responsible for bathing Resident #14 on 06/15/15. She stated she was not aware that Hospice recommended bedrest, so she and the Hospice aide got the resident out of bed with the Hoyer lift and took him/her to the shower room and gave the resident a bath. She revealed the resident was being lifted mechanically out of the tub when the resident just slid out of the chair back into the tub landing on both knees and hitting his/her head on the rim of the tub. She revealed they could not get to the resident fast enough to prevent the fall. She stated the resident did not have any trunk control. She stated she had received training on bathing; however, there was nothing on the nurse aide care card to indicate the resident needed a bed bath. She stated she could not remember if the resident had the seat belt on during the bath and no one asked her about it. She stated Resident #14 was too sick to get out of bed. Interview with Licensed Practical Nurse (LPN) #1, on 06/25/15 at 5:32 PM, revealed Resident #14 did not have good trunk control; however, she did not realize this until the resident fell. She stated she knew the resident was very weak and rarely moved when positioned by staff. She stated nursing staff was to use the bath chair seat belt when moving the resident in or out of the tub. She stated that information was not on the nurse aide care card and she did not know if the seat belt was used or not. She stated she was aware of the Hospice care plan and parts of the care plan were implemented; however, bedbound was not added, as most residents went to the shower	F 323		

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

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F 323	Continued From page 22	F 323		

room for baths. She stated a shower stretcher was not available. She stated she had been trained on writing care plans and updated the plans as needed. She stated she was not trained on determining the root causes of falls.

Interview with the ADON, on 06/26/15 at 11:17 AM, revealed all nurses were trained on determination of the root cause of a fall on orientation and annually. She stated the root cause was what caused the incident and what did the facility fail to do. She stated an intervention to attempt to prevent falls could not be established until the root cause was determined. She stated all resident care plans started with a problem of fall risk. She stated Resident #14 was too sick to get out of bed.

Interview with the DON, on 06/26/15 at 2:09 PM, revealed nursing staff filled out the Risk Management System report when a resident fell. She stated the nurse completed page one (1) and two (2) of the report. She stated the interdisciplinary team reviewed the fall at daily meeting and completed the Risk Management System report which included the root cause analysis. She stated all falls were assessed for the root cause. However, further interview revealed some fall reports were completed using the specifics of the fall and a root cause was not determined.

3. Review of the medical record for Resident #9, revealed the resident was admitted by the facility on 10/06/14, with diagnoses of Alzheimer's Disease and Congestive Heart Failure.

Review of the Quarterly MDS Assessment for

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

(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 323	Continued From page 23	F 323		

Resident #9, revealed the facility assessed Resident #9 to have a severe impairment of cognition, to require extensive assistance with all activities of daily living (ADLs), to be incontinent of bowel and bladder, non-ambulatory and a high fall risk.

Review of the Comprehensive Care Plan for Resident #9, revealed the resident was at risk for falls, dated 10/07/14. Continued review revealed the care plan was last revised for falls on 02/03/15 when Resident #9 slid out of a recliner after using the remote control to raise the seat up into the standing position. The facility added the intervention to keep the recliner remote control out of reach of the resident. However, there was no documented evidence the care plan included Resident #9 sustaining three (3) falls since 02/01/15.

Review of the Risk Management System report, dated 02/01/15, for Resident #9, revealed the resident slid out of his/her recliner after using the remote control to raise the seat up to the standing position. The resident was determined not to be injured at first; however, bruising developed on the right shoulder. The facility determined the cause of the fall to be the resident's confusion and poor safety awareness and the action taken was to keep the remote out of the resident's reach.

Review of the Risk Management System report, dated 03/06/15, revealed Resident #9 was up in a wheelchair in the room and stood and fell onto the right knee. The resident was not injured. The facility determined the cause of the fall was the resident's weakness and the action taken was for the resident to have a non-slip material in the

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

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FORM APPROVED
OMB NO. 0938-0391

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GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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F 323	Continued From page 24 resident's wheelchair and place a tab alarm. Review of the Risk Management System report, dated 05/22/15, revealed Resident #9 had access to the recliner remote control and raised the recliner seat up to standing position causing the resident to slide out of the recliner to the floor. The cause of the fall was the resident's poor safety awareness and the action taken was to keep the remote control out of the resident's reach. Interview with LPN #1, on 06/25/15 at 5:32 PM, revealed Resident #9 used the remote to raise the seat of the recliner to the standing position. She stated the resident fell each time. She stated she did not know how the resident got the remote and was not aware of where and how the remote was stored to keep Resident #9 from having access. She stated the reason the resident fell was related to poor safety awareness. Interview with the DON, on 06/26/15 at 3:39 PM, revealed she was trained on determining the root cause of falls; however, she revealed Resident #9 fell due to the poor safety awareness of the resident. She revealed the staff did all they could and provided adequate supervision to prevent falls in the facility. She stated that she and the Administrator reviewed all falls and she determined the root cause for the falls.	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	F 371		

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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F 371	Continued From page 25 (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F-371-F** **1.** Food service manager is no longer employed. The clean dishes in the plate warmer were removed by the interim Food Service Manager, before meal service on June 24, 2015. The mop that was sitting out was moved by interim Food Service manager and stored in its proper place June 24, 2015. The interim Food service manager dated items opened that date and disposed of other open items June 25, 2015. **2.** All residents have the potential to be affected. The kitchen area and all the equipment will be deep cleaned by an outside contractor on July 9, 2015. The dish rack, kitchen floor, the three metal shelf carts were cleaned on July 9, by the outside cleaning vendor. New mop buckets, mop ringers, and mop heads were ordered on July 7, 2015. Paper signs were removed and replaced as needed with laminated ones on July 29, 2015.	

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, record review and facility policy review, it was determined the facility failed to ensure food was stored, prepared and served in a safe and sanitary environment.

Observations revealed cold food which was potentially hazardous if stored at temperatures greater that forty (40) degrees; unclean stock room floor; opened packages of spaghetti and other noodles; boxes of clear plastic film used to cover food items were located next to a sink and were discolored and damp and the plastic film was uncovered; a broom and two (2) squeegees were stored on the floor with the handles up; the floor in the food preparation area was soiled with bits of food and black streaks; plates were observed to be heavily stained a light brown; and twenty (20) plates were removed from the plate warmer, which had been through the dishwasher, related to food residue on the plates. Additionally, the facility failed to ensure the cleaning schedule was followed.

The findings include:

1. Review of the facility's policy for Department Sanitation, dated 10/12/08, revealed Food and Nutrition Services staff maintained the sanitation of the department by assuring : trash was in

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

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	185285	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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F 371	Continued From page 26 covered containers and emptied when full; cleaning clothes were stored in sanitizing solution when not in use; sanitizing bucket solutions were at the appropriate concentration and were changed frequently during the day; floors were kept clean, free of debris and spills were cleaned up immediately to prevent accidents; equipment was cleaned as soon as possible after use; cleaning schedules were followed and cleaning procedures utilized. Review of the facility's policy Dry Storage, dated 04/01/14, revealed products stored in dry storage areas were maintained in a safe and sanitary manner. Per the Policy, dry bulk items, such as flour, were stored in seamless metal or plastic containers with tight lids, with the containers clearly labeled with the product name and date opened. Review revealed delivery labels from products were maintained until the product was used. Further review revealed disposable products intended for food service use were stored in a sanitary manner using covered, closed, sanitary containers or enclosed food quality plastic bags. Observation of the kitchen, on 06/23/15 at 9:00 AM, revealed breakfast service was finishing. Observation of the coffee cups revealed they were stored, bowl down, in a dish rack on wheels which had wheels covered in a grayish substance with bits of debris present and the rack, along with six (6) others, had black and brown stains. Continued observation revealed a broom with its bristles down and a dust pan stored on the floor and touching the dish rack with the coffee cups. Observation revealed the kitchen floor was sticky around the ovens and the steam table with black and brown dried smears. In addition, there were	F 371	3. All dietary staff will be re-educated on the following policies: hand washing, hair covering, Proper Cleaning procedure, storage of dry foods, and food temps and a post test will be given by July 29, 2015. Staff not available during this time frame will receive re-education including a posttest upon return to work. Interim Food Service manager, Dietician, Administrator, Housekeeping manager, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director will conduct food safety and sanitation audit daily x 2 weeks across all shifts, then 3x/week x 2 weeks then as determined by the monthly Quality Improvement Committee with corrective action if indicated. Any area of concern will be corrected when identified.	

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

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	185265	A. BUILDING _____ B. WING _____	06/26/2015

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F 371	Continued From page 27 three (3) metal three (3) shelf carts in the kitchen with an orange/brown substance on all the shelves. Observation of the kitchen, on 06/23/15 at 10:45 AM, revealed: the floors were sticky and soiled with black and brown smears; the clean dishes in the plate warmer had large light brownish stains; the plate covers had a dried white substance on the inside and outside; the plate warmer was soiled inside and outside with particles and a black greasy substance; the outside of the coffee pots had brown sticky substances in all the crevices; the trays holding, coffee cups, had brown stains; fourteen soiled paper signs were hanging on the walls; two (2) boxes of plastic wrap were sitting on the edge of a sink which had the ends of both boxes damaged and had heavy brown stains and the plastic wrap inside was uncovered; bowls were on a shelf stored bowl up; the dry storage room floor was smeared with a large area of black and brown with debris on the floor in the corners; a bag of spaghetti noodles and a bag of other noodles were opened and not dated; a trash can in the dish washing area had no lid and the outside of the can was heavily soiled with a dried substances; a mop bucket was in the soiled area and the outside of the mop bucket had a black grainy substance; there were two (2) squeegees stored on the floor handle up; and the shelving in the kitchen had debris. Observation of the kitchen, on 06/24/15 at 11:55 AM, revealed: twenty (20) plates in the plate warmer were removed from service after dried eggs were observed on the plates, which had been through the dishwasher; the bullet warmer was soiled on the outside with white and brown particles and a dried orange substance; the	F 371	4. The Administrator will submit a summary of the finding of the audits to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director monthly for 3 months for any additional follow up and/or in-servicing needs. 5. Completion date: August 4, 2015.	8/04/15

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

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FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 28	F 371		

outside of the convection oven was heavily soiled with a greasy substance and dried brown and black drips and particles; and the floors were remained sticky.

2. Review of the facility's policy for Food Handling, dated 03/16/15, revealed food was stored, prepared and served in a safe and sanitary manner. Per the Policy, foods in dry storage would be stored in closed containers. Review revealed all Time/Temperature Control for Safety foods would be prepared and held at forty (40) degrees Fahrenheit or lower, and 145 degrees Fahrenheit or higher while being held for service.

Interview with Dietary Aide #1, on 06/25/15 at 3:01 PM, revealed she knew she was responsible for following the cleaning schedule, however, there were not enough employees to get all the cleaning completed. She stated a dirty kitchen could cause residents to get sick.

Interview with the Food Service Manager, on 06/25/15 at 3:40 PM, revealed he was newly employed by the facility and was responsible for all dietary services. He stated the kitchen lacked enough staff to complete all the cleaning tasks. He stated the staff got confused and made poor decisions without leadership. He stated he was actively looking for new employees and had received applications. He stated the dietary staff had had no leadership due to frequent manager turn-over.

2. Review of the facility's policy for Food Handling, dated 03/16/15, revealed food was stored, prepared and served in a safe and sanitary manner. Per the Policy, foods in dry

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

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	185265	A. BUILDING _____ B. WING _____	06/26/2015

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F 371	Continued From page 29	F 371		

storage would be stored in closed containers. Review revealed all Time/Temperature Control for Safety foods would be prepared and held at forty (40) degrees Fahrenheit or lower, and 145 degrees Fahrenheit or higher while being held for service.

Observation of the kitchen and the meal service, on 06/24/15 at 12:20 PM, revealed a white unidentified food was placed on some residents' trays. Observation at 12:21 PM, revealed the Food Service Manager took the temperature of a dish of the white food and then the white food was removed from the serving line.

Interview with Dietary Aide #1, on 06/24/15 at 12:23 PM, revealed the white food was cottage cheese. She stated some residents enjoyed cottage cheese at lunch. She stated the cottage cheese was not stored on ice during the meal service and a temperature of the item had not been taken prior to the start of the meal service. She stated warm cottage cheese could cause residents to become sick. She stated she did not check the temperatures of cold food prior to the meal service but knew now that she was to do so. She stated she was responsible for the meal service.

Interview with the Food Service Manager, on 06/24/15 at 12:26 PM, revealed the white food was cottage cheese. He stated the temperature of the cottage cheese was 51 degrees Farenheit and the rest of the dishes of cottage cheese were removed from the serving line. He stated the temperature of the cottage cheese should have been 40 degrees Farenheit or lower and should have been checked prior to the start of meal service and placed on ice to prevent food-bourne

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

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FORM APPROVED
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F 371	Continued From page 30 illness. He stated the server was responsible to set-up the food to maintain the proper temperatures.	F 371		
	Interview with the Administrator, on 06/25/15 at 4:15 PM, revealed the Dietary Department had experienced a turn-over of managers and there were open staffing positions which needed to be filled. He stated he had worked with the current staff to get the kitchen cleaned and food served correctly to the residents. He stated he was responsible for the facility.			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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F 431	Continued From page 31	F 431		

permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the Center for Disease Control and Preventions (CDC) Guidelines, it was determined the facility failed to ensure the proper storage and labeling of drugs and biologicals. One (1) vial of Tuberculin Purified Protein Derivative (PPD) was observed to be opened; however, the vial was not labeled or dated as to the time of the opening of the vial.

The findings include:

Review of the CDC Guidelines revealed if a multi-dose vial had been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within twenty-eight (28) days unless the manufacture specified a different (shorter or longer) date for an opened vial. Further review revealed medication vials should always be discarded whenever sterility was compromised or questionable.

Review of the manufacturer's recommendations for the Tuberculin Purified Protein Derivative (PPD) revealed if a vial had been entered and

F-431-D

1. The vial of Tuberculin Purified Protein Derivative was removed from use immediately upon discovery on 6/23/15 by the Unit Manager.

2. All residents have the potential to be affected. All medication carts will be audited by Unit Managers, 3-11 Supervisor, 11-7 Supervisor, or Weekend Supervisor to validate there were no undated open vials present in the medication carts by 8/3/15

3. All nursing staff will be re-educated by Director of Nursing, Assistant Director of Nursing, Unit Managers, Weekend Supervisor, or Licensed Nurses on dating vials upon opening by 8/3/15. A posttest will be given to all nurses by 8/3/15 to validate understanding. Nurses not available during this time frame will receive re-education including posttest by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Weekend Supervisor upon return to work.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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F 431	Continued From page 32 was in use for thirty (30) days it should then be discarded. Further review revealed a medication vial should be discarded after the expiration date if not opened. Observation during a tour of the medication room on 06/23/15 at 12:30 PM, revealed one (1) vial of PPD was observed opened; however, the vial was not labeled or dated as to the date and time it was opened. A copy of the facility and pharmacy policies on medication storage were requested; however, a policy was not received. Interview, on 06/23/15 at 12:35 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager of the nursing floor where the medication room was located, revealed the expectation was all nurses should label and date multi-use medication vials, such as, PPD and insulin vials. Interview with the Director of Nursing (DON) on 06/26/15 at 4:30 PM, revealed it was her expectation all of the facility's nurses label and date all medication and biological vials when they were opened, such as PPD solution and insulin.	F 431	Medication vials will be audited daily x 2 weeks to validate that they have been dated upon opening and then weekly x 2 weeks, then as determined by the monthly Quality Improvement Committee with corrective action if indicated. Any area of concern will be corrected when identified. 4. The Director of Nursing and/or Assistance Director of Nursing will submit a summary of the finding of the audits to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, and Maintenance Director monthly x 3 months for any additional follow up and/or in-servicing needs. 5. Completion date: August 4, 2015	8/04/15

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

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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 Life Safety Code Survey using a 2786S (Short Form) was initiated and concluded on 06/25/15. The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for ninety-five (95) beds. The census the day of the survey was eighty-six (86). Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The Plan of Correction is prepared and executed solely because it is required by Federal and State law.	

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JUL 22 2015

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

Administrator 7/22/15

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.

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT CENTER	201 KIMBERLY LANE WILLIAMSTOWN, KY 41097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were inspected according to National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, ninety-five (95) residents, staff and visitors. The findings include: Review of the automatic sprinkler inspection maintenance record on 06/25/15 at 4:08 PM, with the Administrator, revealed no first quarter inspections for 2015 for the sprinkler system. Interview with the Administrator, during the time of the review, revealed the facility relied on an outside contractor for the sprinkler inspection and was unaware the first quarter sprinkler inspection was missed. Reference: NFPA 25 (1998 Edition) 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to	K 062	**K- 062** **1.** First quarter Fire sprinkler inspection was conducted on April 7, 2015, with no corrective action required. **2.** All residents of the facility have the potential to be affected. The next 4 quarters have been scheduled with the Fire Sprinkler inspection vendor for August 2015, November 2015, February 2016 and May 2016. **3.** Administrator to re-educate maintenance personnel on July 29, 2015, regarding the need for outside vendor inspections being conducted in a timely manner to meet Title 42, Code of Federal Regulations and a posttest given to validate understanding.	

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K 062	Continued From page 2 determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.	K 062	4. Maintenance Director to present monthly, quarterly, semi-annual and annual, conduct by outside vendor inspections each month to the Performance Improvement Committee consisting of the Administrator, Director of Nursing, Activity Director, Social Service Director, Housekeeping Director, Health Information Manager, MDS Coordinator, Admissions Coordinator, monthly for 12 months for any additional follow up and/or re-in-servicing needs. 5. Completion date: August 4, 2015.	8/04/15