

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	
(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 conducted on 04/24/13 through 04/26/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E."	F 000	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 6/3/13.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for one (1) resident (#21), not in the selected sample. Resident #21 attended church services at the facility with wet clothes as the resident could not get staff assistance. Findings include: A record review revealed Resident #21 was admitted to the facility on 11/01/04 with a readmission date of 08/17/12. A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/30/13, revealed the facility identified the resident as cognitively intact and required total assistance with toilet use and transfers.	F 241	F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1. Resident #21 has been provided care in a manner that maintained dignity and respect. 2. All residents have the potential to be affected. 3. All staff will be re-educated on promoting care in a manner that will maintain a resident's dignity and respect, including call light response, by 5/23/13. 4. Compliance will be monitored 5x week by the Administrator and/or DON through observations and resident interviews. They will report findings from documented checks and observations during morning meeting each day and will be documented on the morning review documentation sheet maintained by the Administrator/DON. Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 month with all findings reviewed by QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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

Jimmy Workman

TITLE

Administrator

(X6) DATE

6-15-13

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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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
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F 241	<p>Continued From page 1</p> <p>An interview with Resident #21, on 04/24/13 at 3:00 PM and 04/26/13 at 3:30 PM, revealed State Registered Nurse Aide (SRNA) #1 continually passed by the resident's room, ignoring the call light on 04/20/13. The resident revealed he/she did not want to miss the facility church services at 10:00 AM; therefore, he/she put a blanket in his/her lap and attended the services "wet". Resident #21 revealed the situation made him/her "feel bad".</p> <p>An interview with Resident #22, on 04/24/13 at 3:00 PM and 04/26/13 at 3:40 PM, revealed Resident #21 was his/her roommate. The resident verified that SRNA #1 would not answer the call light to ensure Resident #21 was clean and dry prior to church services.</p> <p>An interview with SRNA #1, on 04/26/13 at 4:45 PM, revealed she was picking up food trays on the hallway when Resident #21 asked to be changed. She revealed when going back to the resident's room at 9:40 AM, the resident had already left for church services. She revealed it was twenty (20) minutes before church started; however, the resident refused care at that time as he/she did not want to be late.</p> <p>An interview with the Director of Nursing (DON), on 04/26/13 at 4:30 PM, revealed she was aware of the situation that occurred on 04/20/13. She revealed she expected staff to ensure the residents were provided care in enough time to attend activities.</p>	F 241	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <ol style="list-style-type: none"> Residents #1, #4, #11, and #13 had comprehensive care plans developed for pacemaker/pacemaker checks implemented on 5/16/13. Resident #3 had care plan for advanced directives changed to full code and a green sticker placed in her chart on 5/23/13. All residents have a potential to be affected. DON/ADON has reviewed all residents with pacemakers to ensure that a comprehensive care plan regarding pacemaker check schedules are in place. Medical Records Director will complete 100% audit of all medical records by 5/23/13 to ensure that each code status and corresponding sticker is correct and in place. DON/ADON will bring new admission charts to morning meeting daily to ensure code status/sticker are in place and to ensure a comprehensive care plan for pacemaker checks has been implanted if needed. Compliance for this process will be monitored 5 x week by Administrator/ DON. Finds will be reported from the documented checks and observations during morning meeting each day and documented on the morning review documentation sheet maintained by the Administrator/DON. Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 months with all findings reviewed by the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279	<p>6/3/13</p>		

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F 279	<p>Continued From page 2</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and failed to ensure the accuracy of comprehensive care plans for five (5) residents (#1, #3, #4, #11 and #13), in the selected sample of fifteen (15) residents. Residents #1, #4, #11 and #13 did not have a comprehensive care plan developed to ensure continuity of care related to having a pacemaker. Resident #3 had an inaccurate care plan developed which addressed the resident's code status.</p> <p>Findings include:</p> <p>1. A record review revealed Resident #1 was</p>	F 279			

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F 279	<p>Continued From page 3</p> <p>admitted to the facility on 04/23/11 with diagnoses to include Pacemaker, Infection resistant to drugs, Conjunctivitis, Dysuria, Weight Loss, Chronic Pain and Squamous Cell Carcinoma.</p> <p>Review of the physician's orders, dated 04/01-30/13 revealed an order to check pacemaker per cardiologist recommendations with a due date of 09/2012. Review of the Transtelephonic Pacemaker Monitoring report revealed the resident had pacemaker checks conducted on 07/22/11, 10/31/11, 03/08/12, 06/25/12 and 09/26/12 being the latest. However, review of the Comprehensive Care Plans revealed there was no care plan developed for the pacemaker to ensure pacemaker checks would be conducted timely.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 07/22/10 with a diagnoses to include Dementia with Behaviors, Embolism Infarction, Depressive Disorder and Congestive Heart Failure.</p> <p>Review of the physicians orders, dated 04/01-30/13 revealed an order to check pacemaker per cardiologist recommendation with a due date of 03/20/13. Review of the Transtelephonic Pacemaker Follow-up Report revealed the checks were conducted at three month intervals on 12/19/11, 03/20/12, 06/19/12, and 09/18/12. Further review of the form revealed the next check would have been due on 12/18/12, however there was no record of the check being done on that date. The last pacemaker check was conducted on 01/30/13 and the next scheduled pacemaker check was scheduled for 04/29/13.</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>A review of the Comprehensive Care Plans for Resident #4 revealed a care plan had not been developed for the pacemaker to ensure the cardiologist's recommendations were being followed to facilitate timely checks of the device and continuity of care.</p> <p>3. A record review revealed Resident #11 was admitted to the facility on 12/07/10 with diagnoses to include Renal Failure, Pneumonia, Pain In Joint, Kidney Neoplasm Malignancy.</p> <p>Review of the physician's order, dated 04/01-30/13, revealed an order "pacemaker check completed 11/21/12". The due date for the next scheduled check was left blank on the physician's order.</p> <p>Review of the medical record revealed no care plan had been developed for Resident #11's pacemaker to ensure pacemakers checks were conducted as recommended.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 04/25/13 revealed she normally develops a care plan for residents with pacemakers, however, the failure to create a care plan for Resident #1, #4 and #11 was an oversight.</p> <p>Interview with the Director of Nursing (DON), on 04/26/13 at 3:55 PM, revealed a care plan should have been developed for Resident #1's pacemaker. She further stated the MDS coordinator had since developed the care plans and placed the care plans on the chart for Resident #1, #4 and #11. She further stated</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>Resident #1 had an appointment to see the cardiologist in March 2013, however he was a "no show" because the family did not take the resident to the appointment. The appointment had not been rescheduled until surveyor inquiry. The appointment was rescheduled for 05/16/13.</p> <p>4. A record review revealed Resident #13 was admitted to the facility on 07/02/10 with diagnoses to include Cerebral Infarction, Pacemaker Placement, Dementia, A-Fib, Coumadin Therapy, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, Right Hemiparesis and Degenerative Arthritis.</p> <p>A record review conducted on 04/26/10 revealed a physician order for a Pacemaker check was ordered for 03/27/13. A record review revealed no documentation in the resident's chart on 03/27/13 of the resident's pacemaker check being completed.</p> <p>A review of the record revealed there was no care plan developed to address the resident's pacemaker checks.</p> <p>An interview conducted on 04/26/10 at 11:30 AM with Resident #13's Licensed Practical Nurse (LPN) revealed pacemaker check had not been completed. She did not know why the pacemaker check had not been completed and rescheduled a pacemaker check for 06/14/13.</p> <p>5. A record review revealed Resident #3 was admitted to the facility on 03/21/13 with diagnoses to include Hypertension, Major Depressive</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>Disorder, Cerebral Vascular Accident, Myocardia Infarction, Diabetes and Congestive Heart Failure.</p> <p>A review of a Code Status Form, dated 03/21/12 completed by Resident #3, revealed the resident requested a "Full Code" status which was verified by her physician on 03/27/13.</p> <p>A review of the Comprehensive Care Plan for Advanced Directives, dated 04/07/13, revealed under the problem heading on the form it was documented the resident had a Do Not Resuscitate Advanced Directive; however, under the approach heading it was documented to confirm the "Do Not Resuscitate" (DNR) wishes per facility policy. A review of Resident #3's April 2013 Medication Administration Record revealed the resident was listed as a Full Code.</p> <p>In addition, observation on 04/25/13 of Resident #3's medical chart revealed there was no red or green sticker on the front of her chart indicating what the resident's code status should be.</p> <p>Interview with the DON and MDS Coordinator, on 04/26/13 at 3:00 PM, revealed the facility policy related to Advanced Directives was to consult with the resident when admitted regarding their code status wishes. The resident's physician should be notified and the physician verifies the code status order. The DON and MDS Coordinator stated Medical Records should place a green sticker on the front of the chart for a full code and a red sticker on the chart for a DNR. In addition, the resident's MAR and TAR should indicate the resident's code status. The MDS Coordinator should develop a comprehensive</p>	F 279			

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F 279	Continued From page 7 care plan indicating the resident's code status request. The DON and MDS Coordinator both stated they were not sure why Resident #3's medical chart contained conflicting data regarding her code status, and they would investigate and immediately correct the situation. The DON stated that it was her expectation that all resident's medical records accurately record their advance directive and full code status on all areas of the chart, and that a correct comprehensive care plan be developed on every resident.	F 279			
F 309 SS=D	483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for two (2) residents (#1 and #13), in the selected sample of fifteen (15) residents related to maintenance checks for pacemakers. Findings include:	F 309			

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F 309	Continued From page 8 1. A record review revealed Resident #1 was admitted to the facility on 04/23/11 with diagnos as to include Pacemaker, Infection Resistant to Drugs, Conjunctivitis Dysuria, Weight Loss, Chronic Pain and Squamous Cell Carcinoma. Review of the physician's orders, dated 04/1-30/13 revealed an order to check pacemaker per cardiologist recommendallons with a due date of 09/2012. Review of the Transtelephonic Pacemaker Monitoring report revealed the resident had pacemaker checks conducted on 07/22/11, 10/31/11, 03/08/12, 06/25/12 and 09/26/12 being the latest. The history of the pacemaker checks appear to be at three month intervals with the exception of one interval between October 2011 and March 2012. According to the medical record the pacemaker had not been checked in seven months as of the survey date of 04/25/13. Additionally there was no documentation indicating what the cardiologist's recommendations were for checking the pacemaker. Interview with the Director of Nursing (DON), on 04/26/13 at 3:55 PM, revealed Resident #1 had not missed anything related to the pacemaker. She stated he had an appointment March 2013 for a comprehensive examination; however, he was a "no show" because the family did not take the resident to the appointment. The appointment was rescheduled on 04/25/13 for 05/16/13 after surveyor inquiry. Review of the Comprehensive Care Plans revealed there was no care plan developed for the pacemaker to ensure pacemaker checks	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Resident # 1 and #13 have physcian orders to complete pacemaker checks every 3 months. 2. Residents with pacemakers have the potential to be affected. 3. DON/ADON has reviewed and updated all medical records and care plans for residents with pacemaker to ensure they have a physician order to complete pacemaker checks every three months as of 5/16/13. DON/ADON will bring all admisson medical records to morning meeting to ensure facility has an order for pacemaker checks every three months and that pacemaker care plan in place if needed. 4. Compliance will be monitored 5x week by the DON/ADON and will report finding during the morning meeting with those findings documented on the morning review documentation sheet maintained by the Administrator/DON . Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 months with all findings reviewed by the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director .	6/3/13

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F 309	<p>Continued From page 9</p> <p>would be conducted timely and according to the cardiologist's recommendation.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 04/25/13 revealed she normally develops a care plan for residents with pacemakers, however, the failure to create a care plan for Resident #1 was an oversight.</p> <p>Interview with the Director of Nursing (DON), on 04/26/13 at 3:55 PM, revealed a care plan should have been developed for Resident #1's pacemaker. She further stated the MDS Coordinator had since developed the care plan and placed on the chart for Resident #1. She further stated in the past she had kept up with ensuring pacemaker checks were conducted timely in word document, however, she had not been able to keep up with it like she should.</p> <p>2. A record review revealed Resident #13 was admitted to the facility on 07/02/10 with diagnoses to include Cerebral Infarction, Pacemaker Placement, Dementia, A-Fib, Coumadin Therapy, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, Right Hemiparesis and Degenerative Arthritis.</p> <p>A record review conducted on 04/26/10 revealed a physician order for a Pacemaker check was ordered for 03/27/13. A record review revealed no documentation in the resident's chart on 03/27/13 of the resident's pacemaker check being completed.</p> <p>A review of the record revealed there was no care plan developed to address the resident's pacemaker checks.</p>	F 309			

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F 309	Continued From page 10 An interview conducted on 04/26/10 at 11:30 AM with Resident #13's Licensed Practical Nurse (LPN) revealed she was sure the pacemaker check had been completed and would verify the information. At 1:00 PM, the LPN revealed that she had contacted the pacemaker check facility and the pacemaker check had not been completed. She did not know why the pacemaker check had not been completed and rescheduled a pacemaker check for 06/14/13.	F 309		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent or greater. The facility had ten (10) medication errors out of forty-one (41) opportunities to equal an error rate of twenty-four percent (24%), involving two residents (#3 and #10) in the selected sample of fifteen (15) residents, and two residents (#19 and #20), not in the selected sample. Findings include: A review of the policy/procedure "Medication Administration General Guidelines", dated 12/12, revealed medications were administered as	F 332		

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	
(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 332	<p>Continued From page 11</p> <p>prescribed in accordance with manufacturers' specifications, good nursing principles and practices. Medications were administered within sixty (60) minutes of scheduled time, except before or after meal orders. At least four (4) ounces (oz) of water or other acceptable liquid should be given with oral medications unless a different amount was specified due to fluid restrictions or product manufacturer requirements. Please note some medications need to be given with more liquid. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought.</p> <p>1. An observation of a medication pass for Resident #3, on 04/25/13 at 9:45 AM, revealed Certified Medication Aide (CMA) #1 administered Cilostazol 100 milligrams (mg), Clonidine Hydrochloride (HCL) 0.2 mg, Hydralazine 100 mg, Labetalol HCL 200 mg, and Miralax 17 gram (gm) powder at 9:45 AM. The Miralax 17 gm powder was administered in four (4) oz of water.</p> <p>A review of the Physician's Orders and Medication Administration Record (MAR) for Resident #3, dated 04/01-30/13, revealed an order for the following medications:</p> <ol style="list-style-type: none"> 1. Cilostazol 100 mg twice daily at 8:00 AM and 8:00 PM 2. Clonidine HCL 0.2 mg three times daily at 8:00 AM, 2:00 PM, and 8:00 PM 3. Hydralazine 100 mg twice daily at 8:00 AM and 8:00 PM 4. Labetalol HCL 200 mg every twelve hours at 8:00 AM and 8:00 PM 5. Miralax Powder 17 gm in eight (8) oz of liquid daily 	F 332	<p>F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <ol style="list-style-type: none"> 1. Residents #3, #10, #19, and #20 have had their medication given per physicians orders. 2. All residents have a potential to be affected. 3. All nurses and CMA's were re-educated on Medication Administration to include administer as prescribed in accordance with manufactures specifications and good nursing principles and practices on 5/20/13 by PharMercla Pharmacy. DON/ADON will complete medication pass competencies for all nurses and CMA's 4. Compliance will be monitored with DON/ADON will completing medication pass audits three times weekly for four weeks, then two times weekly for four weeks and the monthly for two month. Findings will be reported during morning meetings and documented on morning documentation sheet maintained by the Administrator/DON. Findings will be reviewed with QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 	6/3/13

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F 332	<p>Continued From page 12</p> <p>2. An observation of a medication pass for Resident #10, on 04/25/13 at 10:00 AM, revealed CMA #1 administered Lyrica 60 mg and Omeprazole 20 mg at 10:00 AM. Additionally, she allowed Resident #10 to self administer Flonase 60 micrograms (mcg) nasal spray, three (3) sprays to each nostril at 10:00 AM.</p> <p>A review of the Physician's Orders and MAR for Resident #10, dated 04/01-30/13, revealed an order for the following medications:</p> <ol style="list-style-type: none"> 1. Lyrica 50 mg twice daily at 8:00 AM and 4:00 PM 2. Omeprazole 20 mg twice daily at 8:00 AM and 4:00 PM 3. Flonase 0.05% nasal spray one (1) spray in each nostril twice daily at 8:00 AM and 4:00 PM <p>3. An observation of a medication pass for Resident #19, on 04/26/13 at 9:30 AM, revealed CMA #1 administered Acetaminophen 500 mg at 9:30 AM.</p> <p>A review of the Physician's Orders and MAR for Resident #19, dated 04/01-30/13, revealed an order for the following medication:</p> <ol style="list-style-type: none"> 1. Acetaminophen 500 mg caplet every eight (8) hours at 12:00 AM, 8:00 AM, and 4:00 PM <p>An interview with CMA #1, on 04/26/13 at 9:30 AM, revealed she should have reported to the nurse before giving medications out of the scheduled time frame. She verified medications should be administered one hour before or after the scheduled time on the MAR. She revealed she should have given Resident #3 the Miralax in 8 oz of water, per the physician's order; however,</p>	F 332			

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F 332	<p>Continued From page 13</p> <p>she did not read the label or the MAR prior to giving the medication. Additionally, she did not pay attention to Resident #10 while self administering the Flonase nasal spray; however, she should have educated the resident on the correct amount. She was unaware the order specified "one" spray to each nostril, as she thought the order was "two" sprays.</p> <p>4. An observation of a medication pass for Resident #20, on 04/25/13 at 2:00 PM, revealed CMA #2 administered Arthritis Pain Relief, Extended Release (ER) 650 mg crushed in applesauce.</p> <p>A review of the Medications Not to be Crushed, undated, revealed Tylenol Arthritis Caplet should not be crushed as it was a time release formulation.</p> <p>A review of the Physician's Orders for Resident #19, dated 04/01-30/13, revealed to check the "no crush" list prior to crushing medications. The Physician's Orders and MAR, dated 04/01-30/13, revealed an order for the following medication: 1. Arthritis Pain Relief ER 650 mg three times daily</p> <p>An interview with the Director of Nursing (DON), on 04/26/13 at 3:00 PM, revealed she expected staff to follow the facility policy while administering medications. If staff were unable to give a medication within the scheduled time frame, the nurse should be notified to call the physician with further orders. Additionally, she expected staff to administer the medication per the physician's orders. The "do not crush" list of medications was available in the front of the MAR</p>	F 332		

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F 332 F 364 SS=D	Continued From page 14 and should be utilized. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 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 serve food that was prepared in a manner to conserve flavor and appearance and that was palatable for one (1) resident (#23), not in the selected sample. The pureed diet served to Resident #23 was observed to be of a soupy consistency that ran all together on the plate with no separation. Additionally, a test tray of the pureed food revealed a bland starchy taste. Findings include: Review of the facility policy titled, "Mechanically Altered Diet", revealed the purpose was to provide texture-modified foods that require minimal chewing. This diet includes foods modified in texture, such as chopped, ground, mashed and pureed foods, to promote ease of mastication.	F 332 F 364	F364 483.35 (d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 1. Resident #23 has been served a pureed diet of the correct consistency and appropriate taste. 2. All residents on a mechanically altered diet could be affected. 3. The Dietary cooks have been re-educated by the Registered Dietitian on 5/16/13 which included the proper procedure in regards to pureed texture of foods to ensure all puree food items have the appearance of mashed potatoes consistency and to follow puree recipes Dietary staff will taste the pureed food items prior to serving to ensure appropriate taste and any findings that do not meet consistency and taste will be corrected immediately prior to service. 4. Compliance will be monitored with Dietary Manager will conduct audits three times weekly for four weeks, then two times week for four weeks, then monthly for 2 months. Findings will be reported during morning meetings with documentation on the morning documentation sheet. Findings will be reviewed with QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13
	Record review revealed Resident #23 was admitted to the facility on 08/24/11 with diagnoses to include Dysphagia, Osteoarthritis, Epilepsy, and Rheumatoid Arthritis.			

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F 364	Continued From page 15 Review of a physician's order, dated 03/25/13, revealed the resident was to receive a pureed diet with nectar consistency liquids. An observation on 04/25/13 at 12 noon revealed Resident #23 was served a plate of pureed food that was of a soupy consistency. The meal consisted of pork chop supreme, American fried potatoes and Prince Charles vegetable blend. The different foods were observed to have run all together and there was no separation of the different foods. The appearance/color of the food was not attractive. Interview with the Dietary Manager, on 04/26/13 at 12:45 PM revealed the consistency had been brought to her attention and there had been gravy put on the resident's pureed food. An observation of a pureed test tray, on 04/26/13 at 11:40 AM, revealed the pureed cauliflower tasted bland and bitter; therefore, it was not palatable. The food was taste tested by the surveyor and the Dietary Manager. The Dietary Manager agreed the taste of the pureed cauliflower was bland. An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed she expected the pureed cauliflower to taste better before serving to residents, as it tasted "starchy" to her.	F 364			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician.	F 367			

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F 367	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy revealed the facility failed to provide the mechanically altered diet prescribed by the physician for one (1) resident (#23), not in the selected sample. Resident #23 was prescribed a pureed diet on 03/25/13 and was served a diet on 04/24/13 that was not consistent with guidelines for a pureed diet. Findings include: Review of the facility policy titled, "Mechanically Altered Diet", revealed the purpose was to provide texture-modified foods that require minimal chewing. This diet includes foods modified in texture, such as chopped, ground, mashed and pureed foods, to promote ease of mastication. Record review revealed Resident #23 was admitted to the facility on 06/24/11 with diagnoses to include Dysphagia, Osteoarthritis, Epilepsy, and Rheumatoid Arthritis. Review of a physician's order, dated 03/25/13, revealed the resident was to receive a pureed diet with nectar consistency liquids. Review of the Nutritional Assessment, dated 04/04/13 revealed the resident was ordered a puree diet with nectar thick liquids. Review of the Comprehensive Care Plan revealed there was a problem for nutritional and	F 367	F367 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN 1. Resident #23 has received his pureed diet with nectar consistency liquids daily 2. All residents have a potential to be affected. 3. All staff will be re-educated on ensuring that resident #23 and all other residents on mechanically altered diets receive the correct diet/texture during meal service on by the Registered Dietitian/DON/ADON/staff development. Staff will review each tray ticket to ensure that tray has the resident's name with the correct diet prior to giving tray to resident. 4. Dietary Manager will complete audit three times a week for four weeks, then two times a week for four weeks, then monthly times two months to ensure residents received the correct diet. DON/ADON will complete audit three days a week for two weeks and once monthly for two months to ensure resident #23 received the correct diet. Findings will be reported during morning meeting and documented on the morning documentation sheet. Finding will be reviewed with the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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F 367	Continued From page 17 hydration risk related to swallowing difficulty as evidence by choking at meals. Observation, on 04/24/13 at 11:50 AM during the lunch meal, revealed Resident #23 was served meatloaf, mashed potatoes and whole kernel corn. The food was not pureed as ordered by the physician. He was fed by Licensed Practical Nurse (LPN) #1 who fed the resident the mashed potatoes and some of the meatloaf after mashing it up. He was not served any of the whole kernel corn. Interview with the Dietary Manager, on 04/26/13 at 12:10 PM, confirmed that Resident #23 was ordered a pureed diet and stated that someone could have served him the wrong tray. Interview with LPN #1, on 04/26/13 at 3:40 PM, revealed she had already started feeding the resident before she noticed it was not his ordered diet. She was aware it was not his prescribed diet, however, another staff had delivered the wrong tray for Resident #23. LPN #1 stated she would not give him anything to harm him. She was trying not to bring attention to the fact he had been delivered the wrong tray.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, the facility failed to store, prepare, and serve food under sanitary conditions.</p> <p>A review of the Census and Condition, dated 04/24/13, revealed there was a census of sixty (60) resident an fifty-eight (58) residents ate food from the kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the Storage Procedures policy/procedure, undated, revealed food should be covered, dated, and stored loosely to permit circulation of food. Food items should be arranged so that older items would be used first. <p>An observation of the kitchen, on 04/24/13 at 10:16 AM, revealed the following in the refrigerator:</p> <ol style="list-style-type: none"> 1. One container of noctar thickened dairy drink opened 03/19/13, available for use 2. One container of honey thickened orange juice opened, undated, with an expiration date of 03/22/13 3. One container of honey thickened orange juice opened, undated 4. One container of honey thickened dairy drink opened, undated 5. One container neclar thickened cranberry juice opened, undated 	F 371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <ol style="list-style-type: none"> 1. All thickened liquid items in refrigerator have dates of when opened. 2. All residents have a potential to be affected. 3. Dietary staff were re-educated on proper dating of thickened liquids once opened and stored in the refrigerator by the Registered Dietitian on 5/16/13. Cooks were re-educated by the Registered Dietitian on 5/16/13 on the proper procedure to checking food temperatures prior to meal service and proper hand washing after leaving service areas and proper procedure when coming in contact with food in general while taking temperatures. All dietary staff were re-educated by the Registered Dietitian on 5/15/13 on the proper wearing of hairnets while working. 4. The Dietary Manager will complete audits three times a week for four weeks, then two times a week for four weeks, then once monthly times two months to ensure compliance with taking food temperatures properly, dating of thickened liquids, hand washing and wearing of hair nets. Findings will be reported during morning meeting and documented on the morning documentation sheet. Finding will be reviewed with the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. <p>6/3/13</p>	

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F 371	<p>Continued From page 19</p> <p>An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed the liquids in the refrigerator should have been dated when opened, and stored for no more than three (3) days after opening. She revealed the refrigerator was usually checked by her daily; however, she did not notice the undated liquids.</p> <p>2. A review of the Handwashing policy/procedure, undated, revealed employees would use proper hand washing techniques to prevent the spread of infection. All hands would be washed before starting work in the Dietary Department, before and after handling foods, and whenever soiled.</p> <p>A review of the Dietary Dress Code policy/procedure, undated, revealed hair nets or hair restraints were to be worn.</p> <p>An observation in the kitchen, on 04/24/13 at 11:20 AM, revealed the following:</p> <ol style="list-style-type: none"> 1. The cook did not wear gloves while obtaining food temperatures. 2. The food thermometer was dropped in the vegetable soup and the cook placed her finger in the soup to retrieve the thermometer. She continued food temperatures without washing her hands, and did not discard the vegetable soup after contamination. 3. The cook dropped a used alcohol wipe in the carrots and retrieved the wipe with her ungloved hand. She continued food temperatures and did not wash her hands. The carrots were not discarded after contamination. 4. After temperatures were obtained, the cook 	F 371			

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F 371	Continued From page 20 began serving food with visible food particles on her hands. She did not wash her hands or put on gloves. After one tray was served, she donned gloves without washing her hands. 5. The cook left the tray line twice to obtain a bologna sandwich for a resident's tray, and once to obtain a bowl of soup; however, she did not wash her hands or change gloves before returning to the tray line. 6. The cook and server in the kitchen were wearing hair nets; however, the hair on the sides and back were exposed on both staff members. An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed the cook should have used gloves while obtaining food temperatures. She expected the cook to discard the soup and carrots after contamination, they should not have been served to residents. Staff should wash their hands and change gloves after leaving the tray line for any reason. She expected staff to wear a hair net properly, covering all of the hair.	F 371			
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490			

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a Life Safety Code (LSC) survey, conducted 04/24/13, there were three (3) deficiencies cited on the previous annual survey (01/31/12) that had not been corrected. (Refer to K0025, K0027, and K0147) Interview, on 4/24/13 at 4:05 PM, with the Administrator, revealed she was new to the facility since the prior survey. She was unaware of what material was used on the smoke barriers in this facility. She had not personally done an audit of the smoke barriers and she relied on the Plant Operations Manager to ensure the smoke barriers were properly maintained. She had done no audits on the cross-corridor doors since being at this facility. She was unaware of how the coordinating devices on the cross-corridor doors were supposed to function to ensure the doors always closed properly. She had not conducted any audits to determine if there were any power strips used improperly.	F 490	F490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 1. The three previously cited K tag (K0025, K0027, K0147) have been corrected as of 6/3/13. 2. All residents have the potential to be affected. 3. Maintenance documentation will be kept in administrator office to ensure Life Safety Compliance. 4. Findings of maintenance monitoring will be reviewed in facility QA meetings which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 04/26/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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N 000	INITIAL COMMENTS A re-licensure survey was conducted on 04/24/13 through 04/26/13 to determine compliance with state licensure requirements. The facility was found not to meet minimum state licensure requirements with deficiencies.	N 000	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 6/3/13.	
N 113	902 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for one (1) resident (#21), not in the selected sample. Resident #21 attended church services at the facility with wet clothes as the resident could not get staff assistance. Findings include: A record review revealed Resident #21 was admitted to the facility on 11/01/04 with a readmission date of 08/17/12. A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/30/13, revealed the facility identified the resident as cognitively intact and required total assistance with toilet use and transfers. An interview with Resident #21, on 04/24/13 at 3:00 PM and 04/26/13 at 3:30 PM, revealed State Registered Nurse Aide (SRNA) #1 continually passed by the resident's room, ignoring the call	N 113		

Jammy Workman
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6599

TITLE: Administrator
(X6) DATE: 6-14-13
CONZ11

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N 113	Continued From page 1 light on 04/20/13. The resident revealed he/she did not want to miss the facility church services at 10:00 AM; therefore, he/she put a blanket in his/her lap and attended the services "wet". Resident #21 revealed the situation made him/her "feel bad". An interview with Resident #22, on 04/24/13 at 3:00 PM and 04/26/13 at 3:40 PM, revealed Resident #21 was his/her roommate. The resident verified that SRNA #1 would not answer the call light to ensure Resident #21 was clean and dry prior to church services. An interview with SRNA #1, on 04/26/13 at 4:45 PM, revealed she was picking up food trays on the hallway when Resident #21 asked to be changed. She revealed when going back to the resident's room at 9:40 AM, the resident had already left for church services. She revealed it was twenty (20) minutes before church started; however, the resident refused care at that time as he/she did not want to be late. An interview with the Director of Nursing (DON), on 04/26/13 at 4:30 PM, revealed she was aware of the situation that occurred on 04/20/13. She revealed she expected staff to ensure the residents were provided care in enough time to attend activities.	N 113	N 113 902 KAR 20:300-6(1) Section 6. Quality of Life 1. Resident #21 has been provided care in a manner that maintained dignity and respect. 2. All residents have the potential to be affected. 3. All staff will be re-educated on promoting care in a manner that will maintain a resident's dignity and respect, including call light response, by 5/23/13. 4. Compliance will be monitored 5x week by the Administrator and/or DON through observations and resident interviews. They will report findings from documented checks and observations during morning meeting each day and will be documented on the morning review documentation sheet maintained by the Administrator/DON. Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 month with all findings reviewed by QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13
N 189	902 KAR 20:300-7(4)(a) Section 7. Resident Assessment (4) Comprehensive care plans. (a) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive	N 189		

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N 189	Continued From page 2 assessment. This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and failed to ensure the accuracy of comprehensive care plans for five (5) residents (#1, #3, #4, #11 and #13), in the selected sample of fifteen (15) residents. Residents #1, #4, #11 and #13 did not have a comprehensive care plan developed to ensure continuity of care related to having a pacemaker. Resident #3 had an inaccurate care plan developed which addressed the resident's code status. Findings include: 1. A record review revealed Resident #1 was admitted to the facility on 04/23/11 with diagnoses to include Pacemaker, Infection resistant to drugs, Conjunctivitis, Dysuria, Weight Loss, Chronic Pain and Squamous Cell Carcinoma. Review of the physician's orders, dated 04/01-30/13 revealed an order to check pacemaker per cardiologist recommendations with a due date of 09/2012. Review of the Transtelephonic Pacemaker Monitoring report revealed the resident had pacemaker checks conducted on 07/22/11, 10/31/11, 03/08/12, 06/26/12 and 09/26/12 being the latest. However, review of the Comprehensive Care Plans revealed there was no care plan developed for the pacemaker to ensure pacemaker checks would be conducted timely. 2. A record review revealed Resident #4 was admitted to the facility on 07/22/10 with a diagnoses to include Dementia with Behaviors,	N 189	N 189 902 KAR 20:300-7(4)(a)Section 7. Resident Assessment F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1. Residents #1, #4, #11, and #13 had comprehensive care plans developed for pacemaker/pacemaker checks implemented on 5/16/13. Resident #3 had care plan for advanced directives changed to full code and a green sticker placed in her chart on 5/23/13. 2. All residents have a potential to be affected. 3. DON/ADON has reviewed all residents with pacemakers to ensure that a comprehensive care plan regarding pacemaker check schedules are in place. Medical Records Director will complete 100% audit of all medical records by 5/23/13 to ensure that each code status and corresponding sticker is correct and in place. DON/ADON will bring new admision charts to morning meeting daily to ensure code statue/sticker are in place and to ensure a comprehensive care plan for pacemaker checks has been implanted if needed.	

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N 189	<p>Continued From page 3</p> <p>Embolism Infarction, Depressive Disorder and Congestive Heart Failure.</p> <p>Review of the physicians orders, dated 04/01-30/13 revealed an order to check pacemaker per cardiologist recommendation with a due date of 03/20/13. Review of the Transtelephonic Pacemaker Follow-up Report revealed the checks were conducted at three month intervals on 12/19/11, 03/20/12, 06/19/12, and 09/18/12. Further review of the form revealed the next check would have been due on 12/18/12, however there was no record of the check being done on that date. The last pacemaker check was conducted on 01/30/13 and the next scheduled pacemaker check was scheduled for 04/29/13.</p> <p>A review of the Comprehensive Care Plans for Resident #4 revealed a care plan had not been developed for the pacemaker to ensure the cardiologist's recommendations were being followed to facilitate timely checks of the device and continuity of care.</p> <p>3. A record review revealed Resident #11 was admitted to the facility on 12/07/10 with diagnoses to include Renal Failure, Pneumonia, Pain in Joint, Kidney Neoplasm Malignancy.</p> <p>Review of the physician's order, dated 04/01-30/13, revealed an order "pacemaker check completed 11/21/12". The due date for the next scheduled check was left blank on the physician's order.</p> <p>Review of the medical record revealed no care plan had been developed for Resident #11's pacemaker to ensure pacemakers checks were conducted as recommended.</p>	N 189	<p>4. Compliance for this process will be monitored 5 x week by Administrator/ DON. Finds will be reported from the documented checks and observations during morning meeting each day and documented on the morning review documentation sheet maintained by the Administrator/DON. Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 months with all findings reviewed by the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.</p>	6/3/13

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N 189	<p>Continued From page 4</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 04/26/13 revealed she normally develops a care plan for residents with pacemakers, however, the failure to create a care plan for Resident #1, #4 and #11 was an oversight.</p> <p>Interview with the Director of Nursing (DON), on 04/26/13 at 3:56 PM, revealed a care plan should have been developed for Resident #1's pacemaker. She further stated the MDS coordinator had since developed the care plans and placed the care plans on the chart for Resident #1, #4 and #11. She further stated Resident #1 had an appointment to see the cardiologist in March 2013, however he was a "no show" because the family did not take the resident to the appointment. The appointment had not been rescheduled until surveyor inquiry. The appointment was rescheduled for 05/16/13.</p> <p>4. A record review revealed Resident #13 was admitted to the facility on 07/02/10 with diagnoses to include Cerebral Infarction, Pacemaker Placement, Dementia, A-Fib, Coumadin Therapy, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, Right Hemiparesis and Degenerative Arthritis.</p> <p>A record review conducted on 04/26/10 revealed a physician order for a Pacemaker check was ordered for 03/27/13. A record review revealed no documentation in the resident's chart on 03/27/13 of the resident's pacemaker check being completed.</p> <p>A review of the record revealed there was no care plan developed to address the resident's pacemaker checks.</p>	N 189		

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N 189	<p>Continued From page 5</p> <p>An Interview conducted on 04/26/10 at 11:30 AM with Resident #13's Licensed Practical Nurse (LPN) revealed pacemaker check had not been completed. She did not know why the pacemaker check had not been completed and rescheduled a pacemaker check for 06/14/13.</p> <p>5. A record review revealed Resident #3 was admitted to the facility on 03/21/13 with diagnoses to include Hypertension, Major Depressive Disorder, Cerebral Vascular Accident, Myocardia Infarction, Diabetes and Congestive Heart Failure.</p> <p>A review of a Code Status Form, dated 03/21/12 completed by Resident #3, revealed the resident requested a "Full Code" status which was verified by her physician on 03/27/13.</p> <p>A review of the Comprehensive Care Plan for Advanced Directives, dated 04/07/13, revealed under the problem heading on the form it was documented the resident had a Do Not Resuscitate Advanced Directive; however, under the approach heading it was documented to confirm the "Do Not Resuscitate" (DNR) wishes per facility policy. A review of Resident #3's April 2013 Medication Administration Record revealed the resident was listed as a Full Code.</p> <p>In addition, observation on 04/25/13 of Resident #3's medical chart revealed there was no red or green sticker on the front of her chart indicating what the resident's code status should be.</p> <p>Interview with the DON and MDS Coordinator, on 04/26/13 at 3:00 PM, revealed the facility policy related to Advanced Directives was to consult</p>	N 189		

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N 189	Continued From page 6 with the resident when admitted regarding their code status wishes. The resident's physician should be notified and the physician verifies the code status order. The DON and MDS Coordinator stated Medical Records should place a green sticker on the front of the chart for a full code and a red sticker on the chart for a DNR. In addition, the resident's MAR and TAR should indicate the resident's code status. The MDS Coordinator should develop a comprehensive care plan indicating the resident's code status request. The DON and MDS Coordinator both stated they were not sure why Resident #3's medical chart contained conflicting data regarding her code status, and they would investigate and immediately correct the situation. The DON stated that it was her expectation that all resident's medical records accurately record their advance directive and full code status on all areas of the chart, and that a correct comprehensive care plan be developed on every resident.	N 189		
N 199	902 KAR 20:300-8 Section 8. Quality of Care Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident shall receive services and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This requirement is not met as evidenced by: Based on interview and record review, it was	N 199		

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N 199	Continued From page 7 determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for two (2) residents (#1 and #13), in the selected sample of fifteen (15) residents related to maintenance checks for pacemakers. Findings include: 1. A record review revealed Resident #1 was admitted to the facility on 04/23/11 with diagnoses to include Pacemaker, Infection Resistant to Drugs, Conjunctivitis Dysuria, Weight Loss, Chronic Pain and Squamous Cell Carcinoma. Review of the physician's orders, dated 04/1-30/13 revealed an order to check pacemaker per cardiologist recommendations with a due date of 09/2012. Review of the Transtelephonic Pacemaker Monitoring report revealed the resident had pacemaker checks conducted on 07/22/11, 10/31/11, 03/08/12, 06/25/12 and 09/26/12 being the latest. The history of the pacemaker checks appear to be at three month intervals with the exception of one interval between October 2011 and March 2012. According to the medical record the pacemaker had not been checked in seven months as of the survey date of 04/25/13. Additionally there was no documentation indicating what the cardiologist's recommendations were for checking the pacemaker.	N 199	N 199 902 KAR 20:300-8 Section 8. Quality of Care 1. Resident # 1 and #13 have physician orders to complete pacemaker checks every 3 months. 2. Residents with pacemakers have the potential to be affected. 3. DON/ADON has reviewed and updated all medical records and care plans for residents with pacemaker to ensure they have a physician order to complete pacemaker checks every three months as of 5/16/13. DON/ADON will bring all admission medical records to morning meeting to ensure facility has an order for pacemaker checks every three months and that pacemaker care plan in place if needed. 4. Compliance will be monitored 5x week by the DON/ADON and will report finding during the morning meeting with those findings documented on the morning review documentation sheet maintained by the Administrator/DON. Monitoring will continue 5x week for 4 weeks, then twice a week for four weeks, then monthly for 2 months with all findings reviewed by the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	
	Interview with the Director of Nursing (DON), on 04/26/13 at 3:55 PM, revealed Resident #1 had not missed anything related to the pacemaker. She stated he had an appointment March 2013 for a comprehensive examination; however, he was a "no show" because the family did not take the resident to the appointment. The appointment			6/3/13

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N 199	<p>Continued From page 8</p> <p>was rescheduled on 04/25/13 for 05/16/13 after surveyor inquiry.</p> <p>Review of the Comprehensive Care Plans revealed there was no care plan developed for the pacemaker to ensure pacemaker checks would be conducted timely and according to the cardiologist's recommendation.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 04/25/13 revealed she normally develops a care plan for residents with pacemakers, however, the failure to create a care plan for Resident #1 was an oversight.</p> <p>Interview with the Director of Nursing (DON), on 04/26/13 at 3:55 PM, revealed a care plan should have been developed for Resident #1's pacemaker. She further stated the MDS Coordinator had since developed the care plan and placed on the chart for Resident #1. She further stated in the past she had kept up with ensuring pacemaker checks were conducted timely in word document, however, she had not been able to keep up with it like she should.</p> <p>2. A record review revealed Resident #13 was admitted to the facility on 07/02/10 with diagnoses to include Cerebral Infarction, Pacemaker Placement, Dementia, A-Fib, Coumadin Therapy, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, Right Hemiparesis and Degenerative Arthritis.</p> <p>A record review conducted on 04/26/10 revealed a physician order for a Pacemaker check was ordered for 03/27/13. A record review revealed no documentation in the resident's chart on 03/27/13 of the resident's pacemaker check being completed.</p>	N 199		

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N 199	Continued From page 9 A review of the record revealed there was no care plan developed to address the resident's pacemaker checks. An interview conducted on 04/26/10 at 11:30 AM with Resident #13's Licensed Practical Nurse (LPN) revealed she was sure the pacemaker check had been completed and would verify the information. At 1:00 PM, the LPN revealed that she had contacted the pacemaker check facility and the pacemaker check had not been completed. She did not know why the pacemaker check had not been completed and rescheduled a pacemaker check for 06/14/13.	N 199		
N 237	902 KAR 20:300-8(12)(c)1. Section 8. Quality of Care (12) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that: (c) Medication errors. The facility shall ensure that: 1. It is free of significant medication error rates; and This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent or greater. The facility had ten (10) medication errors out of forty-one (41) opportunities to equal an error rate of twenty-four percent (24%), involving two residents (#3 and #10) in the selected sample of fifteen (15) residents, and two residents (#19 and #20), not in the selected sample. Findings include:	N 237		

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N 237	Continued From page 10 A review of the policy/procedure "Medication Administration General Guidelines", dated 12/12, revealed medications were administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. Medications were administered within sixty (60) minutes of scheduled time, except before or after meal orders. At least four (4) ounces (oz) of water or other acceptable liquid should be given with oral medications unless a different amount was specified due to fluid restrictions or product manufacturer requirements. Please note some medications need to be given with more liquid. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. 1. An observation of a medication pass for Resident #3, on 04/25/13 at 9:45 AM, revealed Certified Medication Aide (CMA) #1 administered Cilostazol 100 milligrams (mg), Clonidine Hydrochloride (HCL) 0.2 mg, Hydralazine 100 mg, Labetalol HCL 200 mg, and Miralax 17 gram (gm) powder at 9:45 AM. The Miralax 17 gm powder was administered in four (4) oz of water. A review of the Physician's Orders and Medication Administration Record (MAR) for Resident #3, dated 04/01-30/13, revealed an order for the following medications: 1. Cilostazol 100 mg twice daily at 8:00 AM and 8:00 PM 2. Clonidine HCL 0.2 mg three times daily at 8:00 AM, 2:00 PM, and 8:00 PM 3. Hydralazine 100 mg twice daily at 8:00 AM and 8:00 PM 4. Labetalol HCL 200 mg every twelve hours at 8:00 AM and 8:00 PM	N 237	N 237 902 KAR 20:300-8(12)(c)1. Section 8. Quality of Care 1. Residents #3, #10, #19, and #20 have had their medication given per physicians orders. 2. All residents have a potential to be affected. 3. All nurses and CMA's were re-educated on Medication Administration to include administer as prescribed in accordance with manufactures specifications and good nursing principles and practices on 5/20/13 by PharMerica Pharmacy. DON/ADON will complete medication pass competencies for all nurses and CMA's 4. Compliance will be monitored with DON/ADON will completing medication pass audits three times weekly for four weeks, then two times weekly for four weeks and the monthly for two month. Findings will be reported during morning meetings and documented on morning documentation sheet maintained by the Administrator/DON. Findings will be reviewed with QA team which includes NHA, DON, ADON, MOS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/28/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
(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) COMPLETE DATE
N 237	<p>Continued From page 11</p> <p>5. Miralax Powder 17 gm in eight (8) oz of liquid daily</p> <p>2. An observation of a medication pass for Resident #10, on 04/25/13 at 10:00 AM, revealed CMA #1 administered Lyrica 50 mg and Omeprazole 20 mg at 10:00 AM. Additionally, she allowed Resident #10 to self administer Flonase 50 micrograms (mcg) nasal spray, three (3) sprays to each nostril at 10:00 AM.</p> <p>A review of the Physician's Orders and MAR for Resident #10, dated 04/01-30/13, revealed an order for the following medications:</p> <ol style="list-style-type: none"> 1. Lyrica 50 mg twice daily at 8:00 AM and 4:00 PM 2. Omeprazole 20 mg twice daily at 8:00 AM and 4:00 PM 3. Flonase 0.05% nasal spray one (1) spray in each nostril twice daily at 8:00 AM and 4:00 PM <p>3. An observation of a medication pass for Resident #19, on 04/25/13 at 9:30 AM, revealed CMA #1 administered Acetaminophen 500 mg at 9:30 AM.</p> <p>A review of the Physician's Orders and MAR for Resident #19, dated 04/01-30/13, revealed an order for the following medication:</p> <ol style="list-style-type: none"> 1. Acetaminophen 500 mg ceplet every eight (8) hours at 12:00 AM, 8:00 AM, and 4:00 PM <p>An interview with CMA #1, on 04/26/13 at 9:30 AM, revealed she should have reported to the nurse before giving medications out of the scheduled time frame. She verified medications should be administered one hour before or after the scheduled time on the MAR. She revealed she should have given Resident #3 the Miralax in 8 oz of water, per the physician's order; however,</p>	N 237		

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(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) COMPLETE DATE
N 237	<p>Continued From page 12</p> <p>she did not read the label or the MAR prior to giving the medication. Additionally, she did not pay attention to Resident #10 while self administering the Flonase nasal spray; however, she should have educated the resident on the correct amount. She was unaware the order specified "one" spray to each nostril, as she thought the order was "two" sprays.</p> <p>4. An observation of a medication pass for Resident #20, on 04/25/13 at 2:00 PM, revealed CMA #2 administered Arthritis Pain Relief, Extended Release (ER) 650 mg crushed in applesauce.</p> <p>A review of the Medications Not to be Crushed, undated, revealed Tylenol Arthritis Caplet should not be crushed as it was a time release formulation.</p> <p>A review of the Physician's Orders for Resident #19, dated 04/01-30/13, revealed to check the "no crush" list prior to crushing medications. The Physician's Orders and MAR, dated 04/01-30/13, revealed an order for the following medication: 1. Arthritis Pain Relief ER 650 mg three times daily</p> <p>An interview with the Director of Nursing (DON), on 04/26/13 at 3:00 PM, revealed she expected staff to follow the facility policy while administering medications. If staff were unable to give a medication within the scheduled time frame, the nurse should be notified to call the physician with further orders. Additionally, she expected staff to administer the medication per the physician's orders. The "do not crush" list of medications was available in the front of the MAR and should be utilized.</p>	N 237		

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(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) COMPLETE DATE
N 273 N 273	Continued From page 13 902 KAR 20:300-10(4)(b) Section 10. Dietary Services (4) Food. Each resident shall receive and the facility shall provide: (b) Food that is palatable, attractive and at the proper temperature; 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 serve food that was prepared in a manner to conserve flavor and appearance and that was palatable for one (1) resident (#23), not in the selected sample. The pureed diet served to Resident #23 was observed to be of a soupy consistency that ran all together on the plate with no separation. Additionally, a test tray of the pureed food revealed a bland starchy taste . Findings include: Review of the facility policy titled, "Mechanically Altered Diet", revealed the purpose was to provide texture-modified foods that require minimal chewing. This diet includes foods modified in texture, such as chopped, ground, mashed and pureed foods, to promote ease of mastication. Record review revealed Resident #23 was admitted to the facility on 06/24/11 with diagnoses to include Dysphagia, Osteoarthritis, Epilepsy, and Rheumatoid Arthritis. Review of a physician's order, dated 03/25/13, revealed the resident was to receive a pureed diet with nectar consistency liquids. An observation on 04/25/13 at 12 noon revealed	N 273 N 273	N 273 902 KAR 20:300-10(4)(b) Dietary Services 1. Resident #23 has been served a pureed diet of the correct consistency and appropriate taste. 2. All residents on a mechanically altered diet could be affected. 3. The Dietary cooks have been re-educated by the Registered Dietitian on 5/16/13 which included the proper procedure in regards to pureed texture of foods to ensure all puree food items have the appearance of mashed potatoes consistency and to follow puree recipes Dietary staff will taste the pureed food items prior to serving to ensure appropriate taste and any findings that do not meet consistency and taste will be corrected immediately prior to service. 4. Compliance will be monitored with Dietary Manager will conduct audits three times weekly for four weeks, then two times week for four weeks, then monthly for 2 months. Findings will be reported during morning meetings with documentation on the morning documentation sheet. Findings will be reviewed with QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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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) COMPLETE DATE
N 273	Continued From page 14 Resident #23 was served a plate of pureed food that was of a soupy consistency. The meal consisted of pork chop supreme, American fried potatoes and Prince Charles vegetable blend. The different foods were observed to have run all together and there was no separation of the different foods. The appearance/color of the food was not attractive. Interview with the Dietary Manager, on 04/26/13 at 12:45 PM revealed the consistency had been brought to her attention and there had been gravy put on the resident's pureed food. An observation of a pureed test tray, on 04/26/13 at 11:40 AM, revealed the pureed cauliflower tasted bland and bitter; therefore, it was not palatable. The food was taste tested by the surveyor and the Dietary Manager. The Dietary Manager agreed the taste of the pureed cauliflower was bland. An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed she expected the pureed cauliflower to taste better before serving to residents, as it tasted "starchy" to her.	N 273		
N 276	902 KAR 20:300-10(5) Section 10. Dietary Services (5) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility policy revealed the facility failed to provide the mechanically altered diet prescribed by the physician for one (1) resident (#23), not in the selected sample. Resident #23 was prescribed a pureed diet on	N 276		

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(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) COMPLETE DATE
N 276	<p>Continued From page 15</p> <p>03/25/13 and was served a diet on 04/24/13 that was not consistent with guidelines for a pureed diet.</p> <p>Findings include:</p> <p>Review of the facility policy titled, "Mechanically Altered Diet", revealed the purpose was to provide texture-modified foods that require minimal chewing. This diet includes foods modified in texture, such as chopped, ground, mashed and pureed foods, to promote ease of mastication.</p> <p>Record review revealed Resident #23 was admitted to the facility on 06/24/11 with diagnoses to include Dysphagia, Osteoarthritis, Epilepsy, and Rheumatoid Arthritis.</p> <p>Review of a physician's order, dated 03/25/13, revealed the resident was to receive a pureed diet with nectar consistency liquids.</p> <p>Review of the Nutritional Assessment, dated 04/04/13 revealed the resident was ordered a puree diet with nectar thick liquids.</p> <p>Review of the Comprehensive Care Plan revealed there was a problem for nutritional and hydration risk related to swallowing difficulty as evidence by choking at meals.</p> <p>Observation, on 04/24/13 at 11:50 AM during the lunch meal, revealed Resident #23 was served meatloaf, mashed potatoes and whole kernel corn. The food was not pureed as ordered by the physician. He was fed by Licensed Practical Nurse (LPN) #1 who fed the resident the mashed potatoes and some of the meatloaf after mashing it up. He was not served any of the whole kernel</p>	N 276	<p>N 276 902 KAR 20:300-10(5) Section 10. Dietary Services</p> <ol style="list-style-type: none"> 1. Resident #23 has received his pureed diet with nectar consistency liquids daily 2. All residents have a potential to be affected. 3. All staff will be re-educated on ensuring that resident #23 and all other residents on mechanically altered diets receive the correct diet/texture during meal service on by the Registered Dietitian/DON/ADON/staff development. Staff will review each tray ticket to ensure that tray has the resident's name with the correct diet prior to giving tray to resident. 4. Dietary Manager will complete audit three times a week for four weeks, then two times a week for four weeks, then monthly times two months to ensure residents received the correct diet. DON/ADON will complete audit three days a week for two weeks and once monthly for two months to ensure resident #23 received the correct diet. Findings will be reported during morning meeting and documented on the morning documentation sheet. Finding will be reviewed with the QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 	6/3/13

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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N 276	Continued From page 16 corn. Interview with the Dietary Manager, on 04/26/13 at 12:10 PM, confirmed that Resident #23 was ordered a pureed diet and stated that someone could have served him the wrong tray. Interview with LPN #1, on 04/26/13 at 3:40 PM, revealed she had already started feeding the resident before she noticed it was not his ordered diet. She was aware it was not his prescribed diet, however, another staff had delivered the wrong tray for Resident #23. LPN #1 stated she would not give him anything to harm him. She was trying not to bring attention to the fact he had been delivered the wrong tray.	N 276		
N 282	902 KAR 20:300-10(8)(a) Section 10. Dietary Services (8) Sanitary conditions. The facility shall: (a) Procure food from sources approved or considered satisfactory by federal, state or local authorities; This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, the facility failed to store, prepare, and serve food under sanitary conditions. A review of the Census and Condition, dated 04/24/13, revealed there was a census of sixty (60) resident an fifty-eight (58) residents ate food from the kitchen. Findings include: 1. A review of the Storage Procedures policy/procedure, undated, revealed food should be covered, dated, and stored loosely to permit	N 282		

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N 282	<p>Continued From page 17</p> <p>circulation of food. Food items should be arranged so that older items would be used first.</p> <p>An observation of the kitchen, on 04/24/13 at 10:15 AM, revealed the following in the refrigerator:</p> <ol style="list-style-type: none"> 1. One container of nectar thickened dairy drink opened 03/19/13, available for use 2. One container of honey thickened orange juice opened, undated, with an expiration date of 03/22/13 3. One container of honey thickened orange juice opened, undated 4. One container of honey thickened dairy drink opened, undated 5. One container nectar thickened cranberry juice opened, undated <p>An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed the liquids in the refrigerator should have been dated when opened, and stored for no more than three (3) days after opening. She revealed the refrigerator was usually checked by her daily; however, she did not notice the undated liquids.</p> <p>2. A review of the Handwashing policy/procedure, undated, revealed employees would use proper hand washing techniques to prevent the spread of infection. All hands would be washed before starting work in the Dietary Department, before and after handling foods, and whenever soiled.</p> <p>A review of the Dietary Dress Code policy/procedure, undated, revealed hair nets or hair restraints were to be worn.</p> <p>An observation in the kitchen, on 04/24/13 at</p>	N 282	<p>N 282 902 KAR 20:300-10(8)(a) Section 10. Dietary Services</p> <ol style="list-style-type: none"> 1. All thickened liquid items in refrigerator have dates of when opened. 2. All residents have a potential to be affected. 3. Dietary staff were re-educated on proper dating of thickened liquids once opened and stored in the refrigerator by the Registered Dietitian on 5/16/13. Cooks were re-educated by the Registered Dietitian on 5/16/13 on the proper procedure to checking food temperatures prior to meal service and proper hand washing after leaving service areas and proper procedure when coming in contact with food in general while taking temperatures. All dietary staff were re-educated by the Registered Dietitian on 5/15/13 on the proper wearing of hairnets while working. 4. The Dietary Manager will complete audits three times a week for four weeks, then two times a week for four weeks, then once monthly times two months to ensure compliance with taking food temperatures properly, dating of thickened liquids, hand washing and wearing of hair nets. Findings will be reported during morning meeting and documented on the morning documentation sheet. Finding will be reviewed with the QA team which includes NHA, DON, ADON, MDS, Soc 5vc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director. <p>6/3/13</p>	

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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N 282	<p>Continued From page 18</p> <p>11:20 AM, revealed the following:</p> <ol style="list-style-type: none"> 1. The cook did not wear gloves while obtaining food temperatures. 2. The food thermometer was dropped in the vegetable soup and the cook placed her finger in the soup to retrieve the thermometer. She continued food temperatures without washing her hands, and did not discard the vegetable soup after contamination. 3. The cook dropped a used alcohol wipe in the carrots and retrieved the wipe with her ungloved hand. She continued food temperatures and did not wash her hands. The carrots were not discarded after contamination. 4. After temperatures were obtained, the cook began serving food with visible food particles on her hands. She did not wash her hands or put on gloves. After one tray was served, she donned gloves without washing her hands. 5. The cook left the tray line twice to obtain a bologna sandwich for a resident's tray, and once to obtain a bowl of soup; however, she did not wash her hands or change gloves before returning to the tray line. 6. The cook and server in the kitchen were wearing hair nets; however, the hair on the sides and back were exposed on both staff members. <p>An interview with the Dietary Manager, on 04/26/13 at 12:45 PM, revealed the cook should have used gloves while obtaining food temperatures. She expected the cook to discard the soup and carrots after contamination, they should not have been served to residents. Staff should wash their hands and change gloves after leaving the tray line for any reason. She expected staff to wear a hair net properly, covering all of the hair.</p>	N 282		

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N 282	Continued From page 19 An interview with the Administrator, on 04/26/13 4:55 PM, revealed she expected staff to ensure all policies were followed in the kitchen.	N 282		
N 316	902 KAR 20:300-15 Section 15. Administration A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a Life Safety Code (LSC) survey, conducted 04/24/13, there were three (3) deficiencies cited on the previous annual survey (01/31/12) that had not been corrected. (Refer to K0025, K0027, and K0147) Interview, on 4/24/13 at 4:05 PM, with the Administrator, revealed she was new to the facility since the prior survey. She was unaware of what material was used on the smoke barriers in this facility. She had not personally done an audit of the smoke barriers and she relied on the Plant Operations Manager to ensure the smoke barriers were properly maintained. She had done no audits on the cross-corridor doors since being at this facility. She was unaware of how the coordinialng devices on the cross-corridor doors were supposed to function to ensure the doors always closed properly. She had not conducted	N 316	N316 902 KAR 20:300-15 Section 15. Administration 1. The three previously cited K tag (K0025, K0027, K0147) have been corrected as of 6/3/13. 2. All residents have the potential to be affected. 3. Maintenance documentation will be kept in administrator office to ensure Life Safety Compliance. 4. Findings of maintenance monitoring will be reviewed in facility QA meetings which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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N 316	Continued From page 20 any audits to determine if there were any power strips used improperly.	N 316			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1961 & 1979.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1961, and upgraded in 2012 with 26 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1961 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 04/24/13. Crittenden County Health & Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>		<p>The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 6/3/13.</p>		

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

TITLE

(X6) DATE

Jimmy Workman

Administrator

6-14-13

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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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			
K 025-SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure seven (7) smoke barriers were sealed around pipes and wires to resist the passage of smoke and one (1) smoke barrier was accessible. This deficiency was cited on the previous survey on 02/02/12.	K 025	K025 NFPA 101 LIFE SAFETY CODE STANDARD 1. The seven smoke barriers will be sealed around the pipes/wires with approved sealant for concrete walls to resist the passage of smoke on. Access is available to determine condition of the library wall and any penetration will be sealed with appropriate sealant to prevent passage of smoke. 2. All residents have the potential to be affected. 3. The maintenance director has been re-educated on the use of proper barrier to prevent passage of smoke between smoke compartments by the Administrator on 5/1/13. 4. The maintenance director will visually inspect smoke barriers on a monthly basis to ensure no penetrations. Results will be reported to administrator and reviewed at QA meeting which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13	

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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 04/24/13 at 10:45 AM with the Plant Operations Manager, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by pipes and wires. Further observation revealed drywall mud was used as a sealant on the concreted block walls in the facility. The final observation was the smoke barrier at the library was not accessible to determine the condition of the wall.</p> <p>Interview, on 04/24/13 at 4:05 PM with the Plant Operations Manager, revealed he was unaware drywall mud could not be used as a sealant on a concrete wall. He had checked the smoke barriers for penetrations within the month prior to the survey. He stated there has been new lines ran throughout the facility. He stated he must have missed the penetrations in the smoke barriers.</p> <p>Interview, on 04/24/13 at 4:05 PM with the Administrator, revealed she was new to the facility since the prior survey. She was unaware of what material was used on the smoke barriers in this facility. She had not personally done an audit of the smoke barriers and she relied on the Plant Operations Manager to ensure the smoke barriers were properly maintained. She was aware of the proper material that should have been used to ensure the barriers were properly sealed. She was unaware the smoke barriers were still penetrated by pipes and wires throughout the facility.</p> <p>This is a repeat deficiency.</p>	K 025			

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K 025	Continued From page 3 Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device	K 025			

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K 025	Continued From page 4 that is designed for the specific purpose.	K 025		
K 027 SS#E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eight (8) smoke compartments, sixty (60) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly with the installed door coordinators. This deficiency was cited on the previous survey on 02/02/12.</p> <p>The findings include:</p> <p>Observation, on 04/24/13 between 11:00 AM and 3:45 PM with the Plant Operations Manager, revealed the cross-corridor doors located at room</p>	K 027	<p>K027 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 1. Cross-corridor doors located at room #311, #319, #202 and #419 were adjusted to close completely on 4/26/13 by the maintenance director. 2. All residents have the potential to be affected. 3. Maintenance Director and Administrator were educated on proper closure of cross-corridors by the company's Director of Operations on 4/26/13. 4. Maintenance director will test cross-corridors weekly to ensure proper closure with any concerns addressed immediately. Results will be reviewed with Administrator weekly and findings will be discussed at QA meeting which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 	6/3/13

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
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K 027	<p>Continued From page 5</p> <p>#311, #319, #202, and #419 would not close completely when tested. This was due to the coordinating devices not functioning properly. The doors would not close properly when the doors were opened after the initial close from the magnetic locks.</p> <p>Interview, on 04/24/13 at 4:05 PM with the Plant Operations Manager, revealed the coordinators were installed after the last survey and he was unaware of how they worked properly.</p> <p>Interview, on 04/24/13 at 4:10 PM with the Administrator, revealed she had done no audits on the cross-corridor doors since being at this facility. She was unaware of how the coordinating devices on the cross-corridor doors were supposed to function to ensure the doors always closed properly.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 027			

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K 027	Continued From page 6 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	K029 NFPA 101 LIFE SAFETY CODE STANDARD 1. The dining room/kitchen door has been repaired with larger screws by the facility maintenance director. This door is also scheduled to be replaced in the current facility upgrade project. The Dry storage door has been repaired by tightening screws on the door frame and adjusted the closure by the maintenance director. 2. All residents have the potential to be affected. 3. Facility maintenance director will visually inspect dietary door weekly for proper closure. 4. Compliance will be monitored by documentation of weekly inspections by maintenance and reported to the administrator weekly for 4 weeks, then monthly for 3 months. Findings will be reported to the QA committee which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure the kitchen and the kitchen dry storage were properly protected. The findings include:	K 029		

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K 029	<p>Continued From page 7</p> <p>Observations, on 04/24/13 at 3:23 PM with the Plant Operations Manager, revealed the door from the dining room to the kitchen would not self-close to separate it from the facility. Further observation showed the door closer on the dry storage room in the kitchen would not close the door once the wedge was removed.</p> <p>Interview, on 04/24/13 at 3:23 PM with the Plant Operations Manager, revealed he was unaware the areas doors would not properly close with the automatic door closers installed.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of</p>	K 029		

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K 029	Continued From page 8 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 050 SS=F	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 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to complete a fire drill on 3rd shift during	K 050	K050 NFP 101 LIFE SAFETY CODE STANDARD 1. Fire drills will be held quarterly for each shift and will be conducted at random times. 2. All residents have the potential to be affected. 3. Maintenance director was re-educated by the Administrator on 5/1/13 of the requirement to have completed fire drills quarterly for each shift. Fire drills will be documented on the facility's fire drill report and turned into the Administrator after each drill. 4. Compliance will be monitored on a monthly basis with results reviewed at QA meetings which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13	

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K 050	Continued From page 9 the 3rd quarter of 2012. The findings include: Fire Drill review, on 04/24/13 at 10:55 AM with the Plant Operations Manager, revealed there was no fire drill completed in the 3rd quarter of 2012 on 3rd shift. Interview, on 04/24/13 at 10:55 AM with the Plant Operations Manager, revealed he was unaware the quarter drill was missed on 3rd shift. He conducted an in-service during that time but there was no documentation that a fire drill was conducted. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050			
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 have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of	K 062			

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K 062	<p>Continued From page 10</p> <p>eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure a first quarter sprinkler inspection was conducted during 2013.</p> <p>The findings include:</p> <p>Record review, on 04/24/13 at 10:45 AM with the Plant Operations Manager, revealed the facility did not have documentation for the quarterly inspection of the fire sprinkler system for the 1st quarter of 2013. Components located in the fire sprinkler system must be inspected monthly and quarterly accordingly to NFPA requirements and the records for the inspection made available for the authority having jurisdiction.</p> <p>Interview, on 04/24/13 at 10:45 AM with the Plant Operations Manager, revealed he was unaware the sprinkler system had not been inspected properly.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>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 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</p>	K 062	<p>K062 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 1. Fire sprinkler inspections will be conducted on quarterly basis. 2. All residents have the potential to be affected. 3. Maintenance director was re-educated by the Administrator on 5/1/13 of the requirement of quarterly sprinkler inspections. Sprinkler inspections will be maintained in a notebook located in the administrator's office. 4. Compliance will be monitored monthly by the administrator with results reviewed at QA meetings which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director . <p>6/3/13</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	
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K 062	Continued From page 11 Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or	K 062		

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K 062	Continued From page 12 as needed Chapter 10	K 062			
K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents that smoke, staff and visitors. The facility is certified</p>	K 066	<p>K066 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> Approved ashtrays have been purchased and placed in the two new smoking areas on 5/6/13 by the maintenance director. Both areas were equipped with smoking blankets on 5/14/13 by the maintenance director. Both areas were equipped with fire extinguishers on 5/14/13 by the maintenance director. All residents have the potential to be affected. Maintenance director was re-educated by the Administrator on 5/1/13 of the requirement of equipping all smoking areas with approved ashtrays, fire extinguishers, and smoking blankets. Maintenance director will make week rounds to ensure all areas are adequately equipped. Compliance will be monitored weekly by maintenance rounds to ensure areas are adequately equipped and will be documented on log. Rounds will be made weekly for 4 weeks, then monthly for 3 months. Results will be reported weekly to the Administrator. Findings will be reviewed with facility QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 	6/3/13	

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K 066	<p>Continued From page 13</p> <p>for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into at the gazebo smoking area and the night smoking area.</p> <p>The findings include:</p> <p>Observation, on 04/24/13 at 2:00 PM with the Plant Operations Manager, revealed the smoking areas at the gazebo and the night smoking area did not have a metal container with a self-closing lid to dispose of the cigarette butts. Further observation revealed there were no ashtrays located at two new smoking areas and the areas were not equipped with a fire extinguisher or fire blanket.</p> <p>Interview, on 04/24/13 at 2:00 PM with the Plant Operations Manager, revealed the areas were new smoking areas and he had failed to equip the areas with the required items for a smoking area.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international</p>	K 066		

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K 066	Continued From page 14 symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the kitchen hood suppression system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure the	K 069		

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K 069	<p>Continued From page 15</p> <p>kitchen hood suppression system covered the griddle.</p> <p>The findings include:</p> <p>Observation, on 04/24/13 at 3:33 PM with the Plant Operations Manager, revealed the griddle cooking surface was not completely covered by the kitchen hood suppression system. Further observation revealed the grease fryer did not have the proper separation from the cooking surface.</p> <p>Interview, on 04/24/13 at 3:33 PM with the Plant Operations Manager, revealed he was unaware that the griddle was not properly protected by the kitchen hood and the grease fryer did not have proper separation.</p> <p>NFPA 86 (1998 ed.) 7-1.2 Cooking equipment that produces grease-laden vapors (such as, but not limited to, deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire-extinguishing equipment.</p> <p>NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between</p>	K 069	<p>K069 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 1. Stove/griddle was moved to be under the hood suppression system on 5/10/13 by the facility maintenance director. The Grease fryer has been taken out of service on 5/10/13 by the maintenance director/dietary manager. 2. All residents have the potential to be affected. 3. Facility maintenance director and Dietary Manager were re-educated on the hood suppression system. Maintenance director will make visual inspections of the kitchen hood suppression system. 4. Compliance will be monitored via weekly visual inspections of the kitchen by the maintenance director, documented and reviewed weekly with the administrator. Monitoring will continue weekly for 4 weeks, the monthly for 3 months. All findings will be reviewed with the facility QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director. 	6/3/13	

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K 069	Continued From page 16 the fryer and surface flames of the adjacent appliance.	K 069		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated. The findings include: Observation, on 04/24/13 at 2:30 PM with the Plant Operations Manager, revealed several stuffed animals, wreaths, and artificial floral arrangements throughout the facility had no documentation of flame retardant being applied. Interview, on 04/24/13 at 2:30 PM with the Plant Operations Manager, revealed he was aware decorations were required to be treated with a fire retardant spray but he mostly treated holiday decorations. Reference: NFPA 101 (2000 Edition)	K 073	K073 NFP 101 LIFE SAFETY CODE STANDARD 1. Flame retardant has been applied to the stuffed animals, wreaths, and artificial floral arrangements throughout the facility. 2. All residents have the potential to be affected. 3. Maintenance director was educated by the Administrator on 5/1/13 of the requirement that all combustible decorations be treated by a flame retardant and documented on a log. Compliance will be maintained via weekly rounds by maintenance director/or designee to ensure any new items brought in have been treated and documented. 4. Compliance will be monitored by review of flame retardant logs by the administrator weekly for four weeks, then monthly for 3 months. Findings will be reviewed by QA team which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/ldry, Maint, Business Office, Human resources, Therapy director, and Medical Director.	6/3/13

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K 073	Continued From page 17	K 073	K 147 NFP 101 LIFE SAFETY CODE STANDARD	
K 147 SS=D	<p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, twelve (12) residents, staff, and visitors. The facility is certified for One-Hundred One (101) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure power strips were being used properly on 600 and 600 halls. This deficiency was cited on the previous survey on 02/02/2012.</p> <p>The findings include:</p> <p>Observations, on 4/24/13 between 11:00 AM and 3:45 PM with the Plant Operations Manager, revealed:</p> <p>1) An extension cord was plugged into a power strip that went to the coffee maker located in the floor nurse office. 2) An oxygen concentrator and mini nebulizer were plugged into a power strip located in room</p>	K 147	<p>1. Extension cord from the floor nurse office was removed on 5/1/13 by the facility maintenance director. Room #517, #519, #521, #523, #618, and #610 have been re-wired to add additional electrical sockets and power strips/extensions cords are not in use. Battery Chargers have been discarded as they are not used.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Facility management staff have been re-educated by the Administrator on 4/30/13 regarding the use of power strips and extensions cords. Resident rooms have been re-wired adding additional electrical sockets thus eliminating the need for power strips/extension cords.</p> <p>4. Compliance will be monitored by weekly rounds by the facility maintenance director to ensure power strips/extensions have not been brought into the facility and documented on audit sheet. Rounds will be done weekly for 4 weeks, then monthly for 3 months. Findings will be reported to QA committee which includes NHA, DON, ADON, MDS, Soc Svc, Activity, Dietary, Hskp/Idry, Maint, Business Office, Human resources, Therapy director, and Medical Director.</p>	6/3/13

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K 147	<p>Continued From page 18 #517.</p> <p>3) A mini nebulizer was plugged into a power strip located in room #519.</p> <p>4) An extension cord was plugged into the wall located in room #521.</p> <p>5) An extension cord was plugged into a television located in room #523.</p> <p>6) Battery chargers were plugged into a power strip located in the library.</p> <p>7) A mini nebulizer was plugged into a multi-plug adapter located in room #618.</p> <p>8) An extension cord was plugged into a chair located in room #610.</p> <p>Interview, on 04/24/13 at 4:05 PM with the Plant Operations Manager, revealed he was completing monthly random samples of the rooms to determine if power strips were being properly used. He stated that families bring items into the facility so it is hard to always catch the misused power strips. He also revealed that part of the renovation that is in progress now will include installing outlets to the 500 and 600 halls.</p> <p>Interview, on 04/24/13 at 4:10 PM with the Administrator, revealed she had not performed any audits of resident rooms to determine if power strips in the facility were being used correctly. She was aware of the proper use of the power strips. Since she has been at this facility she has not had an audit conducted by staff to determine if there were any power strips not being properly used. The staff does daily rounds and they have been in-serviced to look at the electrical items in the rooms on their rounds.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p>	K 147		

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K 147	<p>Continued From page 19</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <ol style="list-style-type: none"> 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code. 	K 147		