

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2104D US HWY 421 SOUTH HYDEN, KY 41749	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 01/14-16/13. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to provide effective housekeeping services to maintain a sanitary, orderly, and comfortable interior. A black substance was noted in the grout of the tile flooring in the shower stalls of the men's and women's shower rooms.</p> <p>The findings include:</p> <p>Review of the facility policy for Laundry Staff (dated 06/14/10) revealed laundry staff on the evening shift was to clean the men's and women's showers each evening to prevent mold.</p> <p>Observation of the men's and women's shower stalls on 01/16/13 at 9:30 AM revealed both shower stalls had a black "mold like" substance in the tile grout around the floors.</p> <p>Interview with Housekeeper #1 on 01/16/13 at 2:00 PM revealed the housekeepers were supposed to clean the showers once a day and as needed. The cleaning consisted of cleaning</p>	F 253	<p>F - 253</p> <ol style="list-style-type: none"> The grout in the tile flooring of the men and women's shower stalls was cleaned on 1/16/13. An environmental round was conducted and the facility checked for proper cleaning to ensure that housekeeping and maintenance services have maintained a sanitary, orderly and comfortable environment. Specifically, the grout in the tile flooring in the men and women's shower stalls has been checked for proper cleaning. An in-service was conducted with housekeeping staff by the housekeeping supervisor on 1/16/13 regarding proper cleaning and maintenance services to ensure a sanitary, orderly and comfortable environment; specifically 	

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

Melissa Sparks

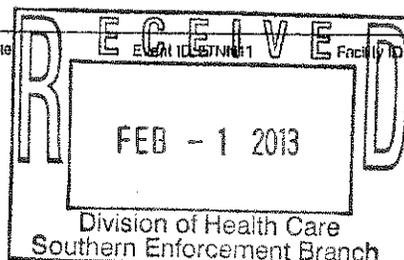
TITLE

Administrator

(X6) DATE

2-1-13

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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 253	Continued From page 1 the floors, the garbage cans, and showers. Housekeeper #1 stated if there was evidence of mold on the flooring, staff scraped the mold from the floor. However, the Housekeeper stated she had not noticed the black "mold like" substance in the shower rooms. Interview with Laundry Employee #1 on 01/16/13 at 9:00 AM revealed laundry staff checked the shower rooms on a weekly basis for mold. The laundry worker also stated she was unaware there was mold in the men's and women's shower rooms. Interview with the Supervisor of the Housekeeping/Laundry Department on 01/16/13 at 2:45 PM revealed the showers were cleaned on a daily basis by housekeeping and laundry staff. The Housekeeping Supervisor stated, "I do weekly checks of the shower rooms and did not notice the black "mold like" substance in the shower rooms."	F 253	cleaning the grout in the tile flooring of men and women's shower stalls. 4. A CQI committee designee will conduct rounds in the facility to ensure that proper cleaning and maintenance services are being provided to maintain a sanitary, orderly and comfortable environment. The rounds will include checking the grout in the tile flooring in the men and women's' shower stalls 3 times per week for one month and then once per week for three months. Any identified concern will be corrected immediately and forwarded to the CQI committee for further review and follow-up.	
F 309 SS=D	483.25 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 observation, interview, record review,	F 309	5. COMPLETION DATE 02/04/2013	

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F 309	<p>Continued From page 2</p> <p>and review of the facility policy, it was determined the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being were provided in accordance with the comprehensive assessment and plan of care for one of eighteen sampled residents (Resident #6). Observation on 01/14/13 of Resident #6 during the evening meal service revealed staff fed the resident the dinner meal in the dining area and the pelvic and thigh area of the resident's pants were observed to be stained. Further observation revealed after the meal service was complete, facility staff placed a tray on the resident's wheelchair and wheeled the resident to an area in front of the nurses' station. Staff failed to ensure incontinence care was provided for the resident prior to the resident's meal, after the meal, and prior to positioning the resident in front of the nursing station in the hallway.</p> <p>The findings include:</p> <p>A review of the facility policy Protocol for Incontinent Care revealed incontinence care will be provided at least every two hours and as indicated. The policy further revealed resident care would be individualized based on the resident's care needs.</p> <p>A review of Resident #6's medical record revealed the facility admitted the resident on 05/03/11 with diagnoses to include Paralysis, Senile Dementia, Kidney Cancer, and Parkinson's Disease. A review of the comprehensive Minimum Data Set (MDS) assessment and care plan dated 11/11/12 revealed Resident #6 was always incontinent of bowel and bladder and</p>	F 309	<p><u>F-309</u></p> <ol style="list-style-type: none"> 1. Resident #6 received incontinence care on 1/14/2013. 2. Residents were observed to ensure that necessary care and services are being provided to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Specifically, all residents are receiving proper incontinence care at least every two hours and as needed. All residents are being provided proper incontinence care prior to meal service to ensure that they are dry, clean and comfortable. 3. In-service education was conducted on 1/14/13 and 1/15/13 with nursing staff 	

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F 309	<p>Continued From page 3</p> <p>required extensive assistance of two persons for toileting.</p> <p>Observations on 01/14/13 at 5:07 PM of Resident #6 revealed the resident was sitting in a wheelchair in the hallway with a lap tray in place and the resident's pants were observed to be stained in the pelvic and thigh area, and a urine odor was noted. Further observation at 5:40 PM of Resident #6 revealed State Registered Nurse Aide (SRNA) #1 wheeled the resident into his/her room in a wheelchair for the evening meal. The SRNA removed the lap tray on the wheelchair, arranged the resident's meal tray, and fed the resident; however, the SRNA failed to provide incontinence care prior to the meal. Resident #6 completed the meal at 6:02 PM and SRNA #1 was observed to wipe the resident's hands and mouth; however, the SRNA failed to provide incontinence care to the resident.</p> <p>Continued observation at on 01/14/13 at 6:02 PM revealed Resident #6 remained seated in the wheelchair and his/her pants continued to be stained in the groin and thigh areas. At that time, SRNA #2 was observed to reattach the resident's lap tray to the wheelchair, wheel the resident into the hall, and leave the resident sitting in the wheelchair in front of the nurses' station. Observations at 6:16 PM revealed facility staff assisted Resident #6 to his/her room and provided incontinence care for the resident.</p> <p>Interview on 01/14/13 at 6:05 PM with SRNA #1 revealed she had not checked Resident #6 to ensure the resident was clean and dry before the SRNA fed the resident and she had not noticed the resident's pants were stained. The SRNA</p>	F 309	<p>by Administrative nursing staff regarding ensuring that all residents receive the care and services necessary to maintain or attain the highest level of physical, mental and psychosocial well-being in accordance with their comprehensive assessment and plan of care. Specifically, the in-service included providing incontinence care to ensure that residents are dry, clean and comfortable during meal service.</p> <p>4. A CQI Committee designee will observe 5 residents per week to ensure that necessary care and services are being provided to residents to attain or maintain the highest level of physical, mental, and psychosocial well-being in accordance with the comprehensive</p>		

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F 309	<p>Continued From page 4</p> <p>acknowledged she should have ensured the resident was clean and dry before the resident was fed.</p> <p>interview on 01/14/13 at 6:11 PM with SRNA #2 revealed she had provided incontinence care to Resident #6 on 01/14/13 at approximately 3:30 to 4:00 PM. The interview further revealed the SRNA had not noticed Resident #6 was wet when she placed the lap tray on the resident's wheelchair and pushed the resident into the hall following the meal on 01/14/13 at 8:02 PM. SRNA #2 stated she should have ensured Resident #6 was clean and dry before taking the resident into the hall in front of the nurses' station.</p> <p>Interview on 01/16/13 at 3:00 PM with Registered Nurse (RN) #2 revealed all staff should ensure residents are clean and dry before feeding a resident a meal. The interview further revealed RN #2 had provided the SRNAs training related to ensuring residents were clean and dry before a meal.</p> <p>Interview on 01/16/13 at 3:15 PM with the Director of Nursing (DON) revealed staff had received in-service training on the importance of ensuring residents were clean, dry, and comfortable before feeding a meal to the resident. The interview further revealed administrative staff made rounds often to ensure care needs of residents were being met. The DON denied the facility had identified any problems with incontinence care not being provided when needed.</p>	F 309	<p>assessment and plan of care. The designee will specifically observe for incontinence care on 5 residents per week for one month and then 5 residents monthly for 3 months. Any identified concern will be corrected immediately and forwarded to the CQI Committee for further review and follow-up.</p> <p>5. COMPLETION DATE 02/04/2013</p>		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 5.</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441	<p><u>F-441</u></p> <ol style="list-style-type: none"> Resident #1 had already been administered the medication which was touched by RN #1's ungloved hand. Resident #1 demonstrated no signs nor symptoms from receiving the medication. RN#1 all other medications in accordance with accepted infection control policies and procedures. Review, observation and interview with staff was conducted to ensure that facility staff are following policies to maintain an infection control program designed to help prevent the development and transmission of disease and infection. All licensed nurses have been observed during medication administration and are following appropriate guidelines for 	

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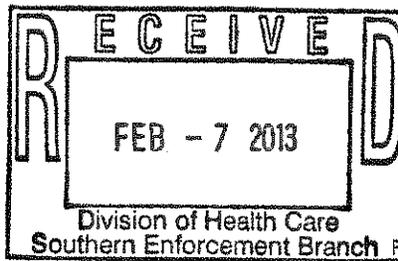
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F 441	<p>Continued From page 6</p> <p>by: Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection. Observation of the medication pass on 01/15/13 at 9:15 AM revealed Registered Nurse (RN) #1 broke a 40 mg Lasix (diuretic) tablet into two pieces using her bare hands and administered one-half of the tablet to Resident #1.</p> <p>The findings include:</p> <p>Review of the facility Infection Control Policy (undated) revealed gloves should be worn when touching contaminated items; however, the policy did not address touching medications with bare hands.</p> <p>A review of Resident #1's physician's orders dated January 2013 revealed the resident was to receive a 20 mg tablet of Lasix at 9:00 AM.</p> <p>Observation of the medication administration pass on 01/15/13 at 9:15 AM revealed there were no Lasix tablets for Resident #1 in the medication cart. RN #1 went to the emergency medication box, obtained a 40 mg tablet of Lasix, and broke the 40 mg tablet of Lasix into two halves using her bare ungloved hands. RN #1 then administered one-half of the 40 mg Lasix tablet to Resident #1.</p> <p>RN #1 acknowledged in interview conducted on 01/15/13 at 10:50 AM that she should have used a pill cutter to break the tablet and should not have used her bare hands to handle the</p>	F 441	<p>infection control. All residents of the facility are receiving medication in accordance with infection control policies and procedures. All Licensed Nurses are administering medication in accordance with infection control policies and procedures.</p> <p>3. An in-service education was conducted on 1/16/13 with licensed nursing staff by administrative nursing staff regarding facility policy to maintain an infection control program to help prevent the development and transmission of disease and infection. Specifically, included in the in-service was information regarding medication administration and infection control policies and procedures</p>	

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F 441	Continued From page 7 medication. Interview with the Director of Nursing (DON) on 01/16/13 at 2:30 PM revealed staff was not to touch medications with bare hands, and staff should have worn gloves to break the tablet into two pieces.	F 441	related to medication administration. 4. A CQI Committee designee will observe medication administration of various licensed nursing staff once per week for one month and then one time per month for three months. Any identified concerns will be corrected immediately and forwarded to the CQI Committee for further review and follow-up. 5. COMPLETION DATE 02/04/2013	



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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1986 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (000) SMOKE COMPARTMENTS: Four COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 01/15/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD	K 000	<u>K-054</u> 1. Notification was made immediately on 1/15/2013 to our contracted service provider to perform the required sensitivity testing of the smoke detectors. The sensitivity testing was conducted on 1/23/2013. 2. The required sensitivity testing of the smoke detectors was conducted on 1/23/2013. Checks were made and records reviewed to ensure that the facility is maintaining the fire alarm system by NFPA standards. 3. Maintenance Staff reviewed requirements of fire alarm system NFPA standards; specifically, smoke detector sensitivity testing on 1/15/13. Maintenance staff will maintain a log of required smoke detector testing.	
K 054 SS=F	All required smoke detectors, including those activating door hold-open devices, are approved.	K 054		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melissa Sparks* TITLE: *Administrator* (X6) DATE: *2-7-13*

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K 054	<p>Continued From page 1</p> <p>maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the fire alarm system by NFPA standards. This deficient practice affected four of four smoke compartments, staff, and all the residents. The facility has the capacity for 94 beds with a census of 88 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/15/13 at 11:40 AM, with the Director of Maintenance (DOM), a record review revealed the last sensitivity testing of the smoke detectors was completed in December 2010. This type of testing is due every two years. An interview on 01/15/13 at 11:40 AM with the DOM revealed he was not aware the smoke detectors needed testing.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the</p>	K 054	<p>4. A CQI Committee designee will review maintenance logs to ensure that the facility is maintaining the fire alarm system in accordance with NFPA standards. The designee will review of the maintenance log of required testing one time per week for one month and then once per month for three months. Any identified concern will be corrected immediately and forwarded to the CQI Committee for further review and follow-up.</p> <p>5. COMPLETION DATE 02/01/2013</p>		

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K 054	Continued From page 2 frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. 7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA	K 054			

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: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH HYDEN, KY 41749		
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K 054	Continued From page 3 standards for the equipment being supervised. 7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054			