

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

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and the Care Area Assessment policy, it was determined the facility failed to revise the care plan for one (1) of four (4) sampled residents (Resident #1) as it related to supervision needs while utilizing a bed</p>	F 280 F 280	<ol style="list-style-type: none"> <li>1. Resident number 1 was discharged from the Facility on 8/24/2014 due to bleeding.</li> <li>2. A 100% audit was completed by the Director of Nursing, Assistant Directors of Nursing, and Unit Managers on all residents to determine if there were any changes in the last 30 days and to ensure the care plan was updated appropriately. The audit was completed on 10/01/2014. No other residents were found to be affected.</li> <li>3. The Director of Nursing reeducated the Assistant Directors of Nursing, MDS Coordinators, Unit Managers, and Licensed nurses on the development and revision of care plans. All new resident charts and residents with change of condition will be brought to the AM Clinical Meeting for review by the Clinical team which consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Quality of Life Director, Chaplain, and Social Services Director, to ensure appropriate care plans are in place and revisions are in place for all change of conditions. This was completed on 10/1/14</li> <li>4. The Director of Nursing will review five resident charts to ensure care plans were developed after</li> </ol>	10/05/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X NHA</i>	(X6) DATE <i>X 10/14/14</i>
---	-----------------------	--------------------------------

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

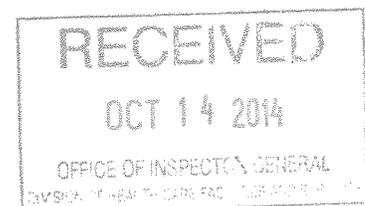
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 280	<p>Continued From page 1 pan.</p> <p>The findings include:</p> <p>Review of the Care Area Assessment policy, revised December 2011, revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when there had been a significant change in the resident's condition.</p> <p>Review of the facility's closed record for Resident #1, revealed he/she was admitted on 08/08/14 with a diagnosis of Respiratory Distress, Sepsis, Malignant Hypertension, and Chronic Obstructive Pulmonary Disease. Review of Resident #1's Nursing Admission Skin Evaluation form, revealed Resident #1 had multiple skin concerns to include superficial open areas on the coccyx.</p> <p>Review of Resident #1's Weekly Skin Assessment form, dated 08/14/14, revealed the resident had a purple bruise in the shape of a horseshoe on the resident's buttocks.</p> <p>Review of Resident #1's Certified Nursing Aide (CNA) Skin Care Alert assessment, dated 08/17/14, revealed the resident had a purple bruise in the shape of a horseshoe on his/her coccyx.</p> <p>Record review of Resident #1's Interim Plan of Care, developed on 08/08/14, revealed the problem was a potential or alteration with bowel function. The goal, which was updated on 08/15/14, was to offer the bedpan and not use briefs.</p> <p>Interview with the Minimum Data Set (MDS)</p>	F 280	<p>assessments were completed and change of conditions were care planned appropriate. These audits will be completed weekly times eight weeks and then monthly times four months. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.</p>	



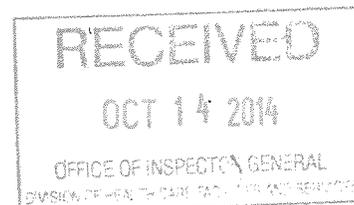
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 280	<p>Continued From page 2</p> <p>Coordinator, on 09/05/14 at 3:37 PM, revealed she did not attend morning meetings. The MDS Coordinator stated the Assistant Director of Nursing (ADON) had the responsibility to take any new orders, update the care plans, and provide interventions as needed. The MDS Coordinator stated if a resident acquired a bruise in the shape of a bedpan, the incident could have been an accident or a supervision problem. The MDS Coordinator stated she would have updated the care plan, and placed supervision of the bed pan under the skin care plan. The MDS Coordinator stated she did not touch the Interim care plans, because it was generated upon admission. She only worked on the Comprehensive Care Plans.</p> <p>Interview with the ADON, on 09/05/14 at 3:50 PM, revealed she would have updated the care plans based on the physician orders. The ADON stated she was informed the area on Resident #1's coccyx was not a bruise, but rather a pink imprint that went away. The ADON stated each resident would have a different skin integrity. The ADON stated when the incident occurred, she did not update the care plan to include close supervision for when the resident was on the bedpan, because she was not painted a clear picture of the incident. The ADON further stated, every resident should be monitored when on the bedpan, not just Resident #1. She felt the care plan should not be updated, because this process was part of the toileting process anyway.</p> <p>Interview with the Director of Nursing (DON), on 09/05/14 at 4:23 PM, revealed she did not specify on the Interim Care Plan a time frame to check on Resident #1 when on the bedpan. The DON stated she wanted to monitor the resident while on the bedpan to ensure the resident did not</p>	F 280		



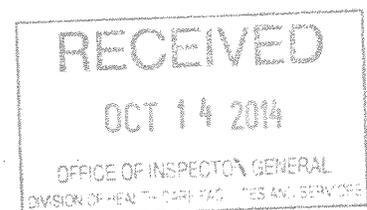
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 280	Continued From page 3 obtain a skin concern. The DON stated she should have updated the care plan so the nurses and the CNAs would have known to increase supervision for Resident #1.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and the Bedpan/Urinal, Offering/Removing Policy, it was determined the facility failed to ensure one (1) of four (4) residents, (Resident #1) received adequate supervision to prevent Resident #1 from sustaining a bruise to coccyx in the shape of a bedpan.  The findings include:  Review of the Bedpan/Urinal, Offering/Removing Policy, revised April 2013, revealed a resident should not be allowed to sit on a bedpan for extended periods. (Note: This is not only uncomfortable to the resident, it also causes skin breakdown.)  Review of Resident #1's closed record, revealed Resident #1 was admitted on 08/08/14 with a diagnosis of Respiratory Distress, Sepsis,	F 323  F 323	1. Resident number 1 was discharged from the facility on 8/24/2014 due to bleeding.  2. An audit will be completed by the Director of Nursing, Assistant Directors of Nursing, and Unit Managers to identify all residents who require assistive devices, including the use of bed pans, to ensure there is adequate supervision to prevent injury. Also, to ensure Care plans are updated with change of condition. Environmental safety audit of resident care areas was conducted by the Plant Operations Director, the Plant Operations Assistant Director, and the Environmental Services Director to ensure facility has provided a safe environment for the residents. No other residents were found to be affected.  3. The Director of Nursing, Assistant Directors of Nursing, and Unit Managers will re-educate the nursing staff on Signatures Policy and Procedures for providing adequate supervision, bed pan policy and procedure and on the safe use of assistive devices. Staff will be re-educated on resident environmental safety by the Environmental Services Director.  4. The Director of Nursing, Assistant Directors of	10/05/2014



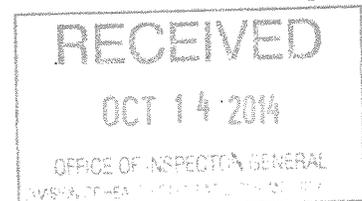
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 4</p> <p>Malignant Hypertension, Chronic Obstructive Pulmonary Disease, and was on Coumadin Therapy. Review of Resident #1's Nursing Admission Skin Evaluation form, revealed Resident #1 had multiple skin concerns to include superficial open areas to the coccyx.</p> <p>Review of Resident #1's Minimum Data Set (MDS), dated 08/20/14, revealed he/she could not be assessed for cognition. Resident #1 was assessed to have an ambulation score of eight (8), which meant the resident was non ambulatory and needed a two (2) person assist with transportation.</p> <p>Review of the Physical Therapy/Treatment Encounter Notes, dated 08/15/14, revealed the recommendation for staff to utilize a bedpan to ensure safety during functional task performance.</p> <p>Record review of Resident #1's Weekly Skin Assessment form, dated 08/14/14, revealed the resident had a purple bruise in the shape of a horseshoe on the buttocks.</p> <p>Record review of Resident #1's Certified Nursing Assistant (CNA) Skin Care Alert assessment, dated 08/17/14, revealed a purple bruise in the shape of a horseshoe on Resident #1's coccyx.</p> <p>Interview with CNA #1, on 09/05/14 at 9:42 AM, revealed she and One-South Unit Manager were on morning rounds, when they discovered Resident #1 had a circular red ring on his/her bottom. CNA #1 stated she did not recall the exact time, but it was right around the first bed check of the morning. CNA #1 stated she and One-South Unit Manager had gathered from the incident that third shift had probably placed</p>	F 323	<p>Nursing, and Unit Managers will complete observation audits and complete use of bed pan competency tool on two staff members per neighborhood to ensure appropriate assistive devices are used correctly and with adequate supervision. This will be completed weekly times eight weeks and then monthly times four months. The Environmental Services Director and Plant Operations Director will conduct environmental safety rounds in resident care areas weekly times eight weeks then monthly times four months. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.</p>	



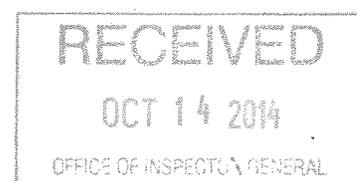
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 5</p> <p>Resident #1 on the bedpan and did not take him/her off the bedpan. CNA #1, stated Resident #1 had so many skin issues that when she applied lotion to the resident, he/she would become red. CNA #1 remembered Resident #1 as being covered with red dots, and had an order for lotion to be applied two (2) to three (3) times per shift.</p> <p>Interview with One-South Unit Manager, on 09/05/14 at 9:12 AM, revealed when CNA #1 asked for assistance with Resident #1, she felt that she could complete a skin assessment at the same time. Resident #1 had some skin issues to include very dry skin with redness. The One-South Unit Manager stated, when CNA #1 rolled Resident #1 over they found the bedpan. CNA #1 then stated the bedpan was placed there before she came in on her shift. The One-South Unit Manager stated she could tell where the bedpan had been, and the mark did not go away within ten (10) minutes. She then reported the incident to the Assistant Director of Nursing (ADON).</p> <p>Interview with CNA #6, on 09/05/14 at 3:15 PM, revealed she worked night shift on the day of the occurrence, and did not remember having placed and removed a bedpan from underneath Resident #1. CNA #6 stated she had heard it was second shift who caused the accident. CNA #6 stated she had no clue how the bedpan had gotten there. CNA #6 stated it was okay to place a resident on a bedpan, cover them up for privacy and check on them no more than ten (10) minutes later. CNA #6 stated she had not seen anything like this before with other residents. CNA #6 stated she did not want the resident to be on the bedpan for very long, so that the resident</p>	F 323		



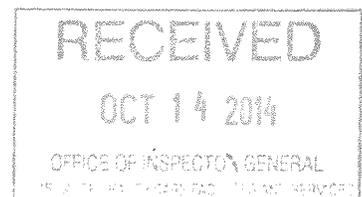
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 6 would not bruise.</p> <p>Interview with CNA #5, on 09/05/14 at 1:16 PM, revealed she worked second shift and remembered she and another aide observed a purple ring in the shape of a bedpan on Resident #1's coccyx. CNA #5 stated Resident #1 did not cry out in pain when cleaned up. CNA #5 stated One-South Unit Manager had found Resident #1's coccyx in that condition. CNA #5 stated she thought it was first shift who caused the injury to Resident #1's coccyx.</p> <p>Interview with the ADON, on 09/05/14 at 10:32 AM, revealed she did not remember the day the incident occurred, but she was familiar with the bedpan incident. The ADON stated One-South Unit Manger asked her around 9:30 AM to look at Resident #1's wound because he/she was on a bedpan for too long and it had left a thin ring. The ADON stated she was unable to assess Resident #1's coccyx, because he/she was sitting up in his/her chair. The ADON stated she did not assess Resident #1's coccyx wound, and was told it was nothing. The ADON stated upon Resident #1's admission she knew Resident #1 had poor skin condition. The ADON stated if she thought it was something to be concerned about she would have had the staff put the resident back in bed so she could assess the wound, but it was portrayed to her as not being an issue, and that the bedpan left a faint ring. The ADON stated the next day she met with the family, and the family voiced that there was still a ring to the resident's bottom. The ADON stated she informed the Director of Nursing (DON) and the DON looked into the matter.</p> <p>Interview with the DON, on 09/05/14 at 4:23 PM,</p>	F 323		



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

PRINTED: 09/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323

Continued From page 7  
revealed she looked at Resident #1's coccyx and did not think it looked bruised. The DON stated Resident #1's bottom looked pink and blanchable. She stated it looked more like petechiae (red or purple spot on the skin caused by broken capillary), and that the circle had started to heal. The DON stated Resident #1 had petechiae all over his/her body. The DON stated the resident was on Coumadin, which delayed his/her healing time. The DON related she felt the resident's skin was just fragile.

Interview with the Administrator, on 09/05/14 at 5:02 PM, revealed there was some confusion as to who was responsible for putting the resident on the bedpan. However, staff members who checked on Resident #1 frequently, stated the resident wanted to stay on the bedpan per his/her request. The Administrator stated she was aware of Resident #1's multiple skin conditions, but did not look at Resident #1's coccyx. The Administrator stated if a resident stayed on a bedpan too long, the resident could develop some skin issues.

F 323

