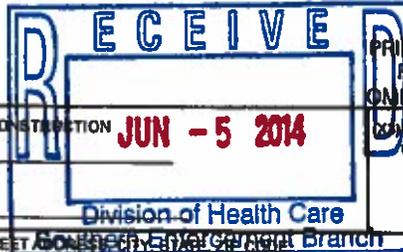


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOD



PRINTED: 06/03/2014
FORM APPROVED
ONE NO. 0938-0391

DATE SURVEY COMPLETED

04/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____
--	--	--

NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS 409 BOMAR HEIGHTS COLUMBIA, KY 42728
---	---

(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	F 000		
F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct a significant change in status assessment when one (1) of twenty-one (21) sampled residents (Resident #1) experienced a major decline in functional status that impacted one or more areas of the resident's health status. Based on a review of quarterly assessments conducted on 12/15/13 and 03/09/14, Resident #1 experienced a decline in cognitive status, bed transfers, dressing, toilet use, and hygiene. Resident #1 also experienced a decline from limited assistance of one staff person to total</p>	F 274	<p>A significant change assessment was completed for Resident #1 on 04/22/14.</p> <p>The Interdisciplinary team was in-serviced by the Director of Nursing on 04/25/14 in compliance with the CMS MDS Manual regarding significant change status assessments. The Interdisciplinary Team reviewed the nursing 24 (twenty-four) hour report on all residents for the last 30 (thirty) days for any noted declines, improvements or changes in residents status to ensure significant change assessments had been completed when appropriate. This was completed on 05/12/14.</p> <p>The Unit Coordinators will review the nursing 24 (twenty-four) hour report monthly to ensure significant change assessments were not missed.</p> <p>Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.</p>	05/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brenda Williams</i>	TITLE <i>Administrator</i>	(X6) DATE 5/16/2014
---	-------------------------------	------------------------

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

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 274	<p>Continued From page 1</p> <p>dependency of one staff person for locomotion on the unit, and for bathing; the resident's locomotion off the unit went from limited assistance of one to "activity only occurred once or twice." In addition, Resident #1 experienced a decline in urinary status from occasionally incontinent to the use of an indwelling urinary catheter; and the resident declined from continent of bowel to always incontinent. The resident also experienced a significant weight loss and a Stage III pressure area to the coccyx.</p> <p>The findings include:</p> <p>The facility Administrator stated on 04/24/14 at 3:00 PM that the facility did not have a specific policy for significant change in status assessments. The Administrator stated the facility utilized the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) user manual, version 3.0.</p> <p>Review of the CMS RAI manual, version 3.0, Chapter 2, pages 20 and 21, revealed a significant change was a decrease or improvement in a resident's status that would not normally resolve without intervention by staff, was not self-limiting, impacted more than one area of the resident's health status, and required interdisciplinary review/revision of the care plan.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 06/04/12 with diagnoses that included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes, Hypertension, Bilateral Above the Knee Amputations, Arterial Sclerotic Vascular Disease, and Cirrhosis of the Liver. Review of the quarterly assessment on 12/15/13 revealed a</p>	F 274			

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 274	<p>Continued From page 2</p> <p>Brief interview for Mental Status (BIMS) score of 14, indicating an "intact" cognitive level, transferred in and out of bed, dressed, used the toilet, and performed hygiene/bathing with extensive assistance of one staff person. Resident #1 was assessed to have limited assistance of one person for on and off the unit locomotion, was occasionally incontinent of bladder, was continent of bowels, and had no pressure areas.</p> <p>Based on the review of the medical record, Resident #1 had a hospital stay from 12/31/13 through 01/06/14, and a hospital stay from 02/11/14 through 02/24/14.</p> <p>Review of the quarterly assessments for Resident #1 dated 12/15/13 and 03/09/14, revealed the resident experienced a decline in decision-making from an intact cognitive level to a moderately impaired cognitive level; a decline from extensive assistance of one staff person to extensive assistance of two staff persons for transfers in and out of bed, dressing, toilet use, and hygiene/bathing skills. The facility also assessed Resident #1 to experience a decline in his/her locomotion abilities on the unit from limited assistance of one staff person to total dependence of one staff person; and a decline in locomotion off the unit from limited assistance of one person to "the activity did not occur but once or twice." Resident #1 experienced a decrease in his/her abilities to eat and went from "supervision" of the resident's meals to the assistance of one staff person for meals. The facility assessed Resident #1 to have a decrease in continence, which indicated the resident went from continent of bowels to always incontinent of bowels and from occasionally incontinent of bladder to the</p>	F 274			

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 274	<p>Continued From page 3</p> <p>use of an indwelling urinary catheter. Resident #1 also experienced a weight loss from 121 pounds to 113 pounds in a three-month timeframe, which indicated a significant loss in weight. In addition, Resident #1 developed a Stage III pressure area to the coccyx area. Based on a review of assessments, Resident #1's decision-making abilities declined from "independent" on the assessment conducted on 12/15/13 to "modified" independence on 03/09/14; and the resident's BIMS score declined from 14, cognitively intact, on 12/15/13 to 9, moderately intact on 03/09/14.</p> <p>A review of Resident #1's Comprehensive Care Plan updated 03/09/14 revealed all the care areas that had declined were addressed in the plan of care. However, the facility failed to conduct a significant change in status assessment as required when the resident experienced a significant decline in his/her physical or mental condition.</p> <p>Interview with Minimum Data Set (MDS) Coordinator #1 on 04/28/14 at 2:00 PM revealed the facility held morning team meetings Monday through Friday to discuss resident assessment and health status changes. According to the MDS Coordinator, when a resident had more than one change that affected the resident's health care status, staff would conduct a significant change assessment. MDS Coordinator #1 stated the facility staff should have conducted a significant change assessment of Resident #1 on 03/09/14 instead of a quarterly assessment. The MDS Coordinator stated staff had missed the significant change assessment after Resident #1's discharge from the hospital on 02/24/14.</p>	F 274			

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 274	Continued From page 4 Interview with the Director of Nursing (DON) on 04/24/14 at 3:45 PM revealed a significant change assessment should have been conducted for Resident #1 on 02/24/14.	F 274			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	F 278 The MDS Interdisciplinary Team reviewed Resident #9's current MDS on 04/25/14 to ensure the resident's behavioral symptoms were coded accurately. A quarterly MDS was completed on 5/29/14 to ensure Resident #9's behavioral symptoms were coded accurately. All current MDS's on residents who were noted to be non-compliant with care were reviewed by the Interdisciplinary Team on 05/14/14 to ensure the residents' behavioral symptoms were coded accurately. Nursing staff were educated by the Director of Nursing to document noncompliance/rejection of care in Care tracker and/or COMS in order for it to be coded on MDS and be validated by 05/14/14. Resident #9's care plan was updated on 4/24/14. All new nursing employees will be educated by the Director of Nursing or designated Unit Coordinator on how/where to document noncompliance/rejection of care upon hire and annually thereafter. F278 continued on next page.....		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 278	<p>Continued From page 5</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure assessments coded on the Minimum Data Set (MDS) accurately reflected the status for one (1) of twenty-one (21) sampled residents (Resident #9). Record review of Resident #9's MDS assessments revealed the assessment did not accurately reflect the resident's failure to request assistance with ambulation and transfers.</p> <p>The findings include:</p> <p>Review of the facility's policy "Nursing Documentation, Comprehensive Assessment and Care Plan," not dated, revealed each resident's medical, nursing, mental, and psychosocial needs would be identified in the Comprehensive Assessment.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 01/31/13 with diagnoses of Difficulty in Walking, Generalized Muscle Weakness, Lack of Coordination, Personal History of Falls, and Anxiety. Review of the quarterly MDS dated 11/06/13 revealed the facility assessed the resident to require supervision with transfers and ambulation. Review of a significant change MDS dated 12/11/13 revealed the resident experienced a fall with injury on 11/30/13 and at that time the facility assessed the resident to require extensive assistance with transfers and the assistance of two (+) with ambulation. Review of the quarterly MDS dated 03/03/14 revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 15, meaning the resident's cognition was found to be intact.</p> <p>Review of the facility's Fall Tracking Log revealed</p>	F 278	<p>F278 continuation.....</p> <p>The Interdisciplinary team was in serviced by the Director of Nursing regarding assessments coded on the MDS to accurately reflect the status of the resident on 04/25/14.</p> <p>We will audit 5 MDS's per week for 2 (two) weeks; then 10 MDS's per week per month for 3(three) months; then 15 MDS's per quarter for 1 (one) year to ensure it accurately reflects the status of the resident.</p> <p>Finding will be presented to the Quality Assurance committee quarterly for 1 (one) year.</p>	05/29/14	

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 278	<p>Continued From page 6</p> <p>on 11/30/13, at 2:00 PM, Resident #9 experienced a fall, and stated that he/she thought his/her "hip is broken." The facility transferred the resident to the Emergency Department (ED) and the resident was diagnosed to have a fractured hip. Continued review of the incident revealed facility staff determined the resident "had cane walking, fell back" as the "cause of fall." Continued review of the Falls Tracking Log revealed the resident experienced falls on 02/03/14 at 6:40 PM (slid off the bed after an attempt to put self to bed, and was assessed to have an abrasion to the right side of the back); on 02/08/14 at 6:40 PM (attempted to transfer self from recliner to wheelchair); on 02/17/14 at 6:30 PM (up from wheelchair attempting to get clothes from closet); on 03/11/14 at 6:20 PM (stood up with walker in socked feet; complained of right side pain); on 03/17/14 at 7:35 PM (walking with walker and shoes slipped, bruised noted on the right arm); and on 03/19/14 at 7:15 PM (got up from table and sat down). Record review revealed the falls Resident #9 experienced from 11/30/13 to 03/19/14 occurred in the resident's room, and the resident had not requested assistance from staff prior to the falls.</p> <p>Review of a significant change in status assessment dated 12/11/13 and a quarterly assessment dated 03/03/14 revealed the facility coded Section E0800 (Rejection of Care - Presence and Frequency, e.g. "blood work, taking medications, ADL assistance") as "0-Behavior not exhibited."</p> <p>Observation of Resident #9 on 04/23/14 at 4:37 PM revealed the resident standing in front of a wheelchair, unassisted, trying on clothes.</p>	F 278			

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 490 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 278	Continued From page 7 Interview with Resident #9 on 04/24/14 at 3:50 PM revealed the resident was aware he/she was to request assistance with transfers/ambulation. According to Resident #9, "I know that I'm supposed to call them for help but I still get up on my own." Interviews with MDS Coordinators #1 and #2 on 04/24/14 at 3:43 PM revealed they were aware Resident #9 failed to request help with transfer/assistance. MDS Coordinator #1 stated the resident was aware to request assistance and stated the resident "chooses to not comply with that." Interview with the Social Services Director on 04/24/14 at 4:05 PM revealed that the Social Services Department was responsible to complete Section E0800, the "Mood/Behavior" sections in the MDS assessments. The Director acknowledged that Resident #9 is "noncompliant as far as asking for assistance," and stated, "I had not identified that on the MDS and it should have been part of their assessment." Interview with the Administrator on 04/24/14 at 12:00 PM revealed that she was aware that Resident #9 was noncompliant with asking for assistance with ambulation and transfers and acknowledged the information should have been part of the resident's assessment. The Administrator stated, "I've talked to [the resident] several times about asking for assistance." In addition, the Administrator stated, "Not asking for help should be part of [the resident's] assessment."	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279 Continued on next page.....		

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 279	Continued From page 8 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies it was determined the facility failed to develop a comprehensive plan of care related to noncompliance with assistance for ambulation and transfers for two (2) of twenty-one (21) sampled residents (Residents #9 and #10). Record review of Resident #9's comprehensive plan of care revealed the facility assessed the resident to require assistance to transfer/ambulate, but failed to address the resident's noncompliance with requesting assistance. In addition, the facility failed to develop a plan of care to address Resident #10's history of a past positive Purified Protein	F 279	F 279 continuation..... The MDS Coordinator updated care plans for resident #9 and #10 on 04/24/14. The care plans will be reviewed for all residents with a history of (+) PPD as well as all residents who staff have reported to be non-compliant with care by 05/01/14. The Director of Nursing will educate the Inter-Disciplinary team on how to write a care plan to accurately reflect residents needs on 05/14/14. The MDS Coordinators will review 7 (seven) residents care plans per week for 4 (four) weeks; then 10 (ten) per month for 3 (three) months; then 15 (fifteen) per quarter for 1 (one) year to ensure accuracy. Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.	05/19/14	

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 279	<p>Continued From page 9</p> <p>Derivative (PPD) Tuberculin (TB) skin test that included monitoring for complications or signs/symptoms of tuberculosis.</p> <p>The findings include:</p> <p>Review of facility policy titled "Nursing Documentation, Comprehensive Assessment, and Care Plan" not dated, revealed, "The care plan will include need/problem, goals, approaches, discipline responsible, measurable objectives, and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the Comprehensive Assessment."</p> <p>1. Review of Resident #9's medical record revealed the facility admitted the resident on 01/31/13 with diagnoses of Difficulty in Walking, Generalized Muscle Weakness, Lack of Coordination, Personal History of Falls, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated 03/03/14 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated 12/11/13 revealed Resident #9 required the physical assistance of two "+" (plus) persons for transfers and walking in the room.</p> <p>Review of Resident #9's comprehensive care plan and Ongoing Nursing Assistant Care Plan revealed the facility addressed the resident's requirement for assistance with transfers and ambulation but failed to address the resident's</p>	F 279		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 279	<p>Continued From page 10 noncompliance to request assistance.</p> <p>Interview with Resident #9 on 04/24/14 at 3:50 PM revealed the resident was to use his/her call light to request assistance with transfers/ambulation and stated, "I know that I'm supposed to call them for help but I still get up on my own."</p> <p>Interview with Registered Nurse (RN) #2 on 04/24/14 at 11:12 AM revealed staff was aware the resident frequently failed to request staff assistance when he/she got up from the wheelchair and attempted to self-transfer. RN stated the resident did not always request assistance and would transfer from the bed/chair and ambulate unassisted. RN #2 acknowledged staff should have included the resident's noncompliance with requesting assistance with transfers/ambulation in the care plan, and stated, "If (he/she) wasn't going to follow what we asked, we should have put that on the care plan."</p> <p>Interview with the Director of Nursing (DON) on 04/24/14 at 4:45 PM revealed staff had informed the resident to request assistance with transfers and ambulation and stated the resident failed to request assistance at times. According to the DON, staff was aware the resident did not always request assistance and stated, "It should have been addressed better on the care plan."</p> <p>2. Review of the medical record revealed the facility admitted Resident #10 on 05/30/13 with diagnoses that included Dementia and Depression. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/05/14, revealed Resident #10's Brief Interview for Mental Status (BIMS) score was fifteen (15) which</p>	F 279			

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 279	Continued From page 11 Indicated the resident's cognition was intact. A review of the immunization record revealed the resident had a history of a positive reaction to the Purified Protein Derivative (PPD) skin test (test to determine the presence of tuberculosis). Review of the comprehensive care plan for Resident #10 dated 03/11/14 revealed the facility failed to develop a plan of care to address the resident's history of a past positive PPD skin test that included monitoring for complications or signs/symptoms of tuberculosis. Interview with Director of Nursing (DON) on 04/24/14 at 7:39 PM revealed staff have meetings every Monday and review the care plans. In addition, the DON stated direct care staff was to review the care plans on a daily basis and update the care plans when needed. The DON acknowledged staff had failed to ensure Resident 10's care plan had been updated to include monitoring for signs/symptoms of TB.	F 279			
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies, it was determined the facility failed to ensure services were provided in accordance with the written plan of care and physician's orders related to oxygen	F 282	F282 04/24/14 RN Supervisor #1 changed oxygen to appropriate liter as ordered. F282 Continued on next page.....		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 282	<p>Continued From page 12</p> <p>therapy for one (1) of twenty-one (21) sampled residents (Resident #5). Resident #5 had a physician's order for oxygen at 3 liters per minute by nasal cannula, as needed. In addition, review of Resident #5's comprehensive plan of care revealed staff would administer the resident's oxygen as ordered by the physician. However, observation of Resident #5 on 04/22/14 and 04/23/14 revealed the resident's oxygen setting had been set at 2 liters per minute.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Nursing Documentation, Comprehensive Assessment, and Care Plan," undated, revealed the comprehensive plan of care would include the problem, goals, approaches, discipline responsible, measurable objectives, and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment.</p> <p>Review of Resident #5's medical record revealed the facility admitted Resident #5 on 04/23/07 with diagnoses that included Congestive Heart Failure, Hypertension, and Cardiomegaly. A review of physician's orders dated 06/27/13 revealed an order for oxygen, at 3 liters "per minute" on an as needed basis. Review of the Minimum Data Set (MDS) annual assessment dated 01/18/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 99, which indicated the resident was unable to be interviewed.</p> <p>Review of Resident #5's Comprehensive Care Plan dated 01/28/14 revealed staff would administer the resident's oxygen as ordered.</p>	F 282	<p>F282 Continuation.....</p> <p>04/24/14 all residents receiving oxygen were checked for appropriate oxygen settings.</p> <p>04/25/14 the Director of Nursing began in-servicing nursing staff regarding the Nurse being responsible for setting the oxygen concentrators according to physician orders. The flow rate will be noted on the Medication Administration Record for the nurse to check every shift. The State Registered Nursing Assistants were in-serviced regarding checking concentrators to ensure that they are set according to the nurse aid care plan and to report any discrepancies immediately to the Nursing Supervisor. The Director of Nursing conducted several in-services for the SRNA's beginning on 04/25/14 with the final in-service completed on 05/29/14.</p> <p>The Unit Coordinator will audit all residents on oxygen daily times 1 (one) week; then weekly times 2 (two) months; then quarterly times 1 (one) year to ensure the concentrators are set on the appropriate setting.</p> <p>Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.</p>	05/29/14	

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 282	<p>Continued From page 13</p> <p>Based on a review of the care plan, staff failed to establish a plan and/or develop interventions that included goals, approaches, or measurable objectives for the use of the oxygen. In addition, the facility failed to plan an individualized care plan to address the criteria/guidance for the use of the oxygen on an as needed basis.</p> <p>Observations of Resident #5 on 04/22/14 at 3:17 PM and 3:54 PM, and on 04/23/14 at 9:17 AM, 11:40 AM, and 2:14 PM revealed oxygen was in use by the resident and set at 2 liters per minute.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on 04/23/14 at 3:28 PM revealed she did not know the rate at which Resident #5's oxygen was to be delivered and stated the nurses adjusted the oxygen according to physician orders.</p> <p>Interview with State Registered Nurse Aide (SRNA) #5 on 04/23/14 at 3:37 PM revealed she was not permitted to adjust the rate of oxygen but if she noticed the oxygen was on the wrong rate she was required to inform the nurse. According to SRNA #5, she was aware of the correct rate of Resident #5's oxygen but had failed to check the rate "yesterday."</p> <p>Interview with Registered Nurse (RN) #1 on 04/24/14 at 5:40 PM revealed she monitored each resident's oxygen saturation level and the rate at which oxygen was delivered at the beginning of every shift. RN #1 stated she was not readily aware of the rate the physician had prescribed for Resident #5. According to RN #1, she referred to the physician orders and care plans to ensure the oxygen was delivered as ordered when she monitored residents that had</p>	F 282			

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 282	Continued From page 14 oxygen ordered.	F 282			
F 323 SS=D	<p>Interview with the Director of Nursing (DON) on 04/24/14 at 7:39 PM revealed nurses were required to make rounds three to four times daily to ensure oxygen was administered at the rate prescribed by the physician and in accordance with the plan of care. The DON stated she also made rounds daily and had not identified any concerns related to oxygen administration.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policies, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for one (1) of twenty-one (21) sampled residents (Resident #9). Facility staff assessed Resident #9 to be alert and oriented and noted the resident had limited mobility and required staff assistance with transfers and ambulation. Documentation revealed facility staff informed the resident he/she would need to request assistance with transfers and ambulation. Based on interview and documentation in the medical record, Resident #9 failed to request assistance with</p>	F 323	<p>F 323</p> <p>The Director of Nursing analyzed trends with falls on Resident #9 on 04/28/14 to ensure interventions were appropriate.</p> <p>Unit Coordinators' will analyze trends on all residents that had a fall in the last 30 days to ensure interventions applied are appropriate. The analysis was completed on 05/14/14.</p> <p>The falls committee was educated by the Skilled Nursing Facility Clinical Consultant to apply interventions related to the cause of the fall and to analyze trends on 05/14/14.</p> <p>The falls committee will review falls weekly on all residents who fell during the previous week to ensure appropriate interventions have been applied and trends were analyzed. This process will be on going weekly times 1 (one) year.</p> <p>The findings will be presented to the Quality Assurance committee quarterly for 1 (one) year.</p>	05/29/14	

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 15</p> <p>transfers/ambulation on numerous occasions and experienced falls, one of which resulted in a fracture of the resident's hip on 11/30/13. Interviews revealed the facility had tracked and trended the falls sustained by Resident #9, however, the facility failed to analyze trends related to the falls sustained by Resident #9 to ensure interventions were developed based on the analysis and/or assessment.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Falls Management," effective 01/01/10 revealed the facility would screen all residents to identify possible risk factors that place a resident at risk for falls, to evaluate the risks, implement interventions to reduce those risks, and to monitor those interventions and modify the interventions when necessary. In addition, the policy revealed the facility would track the individual falls (Falls Tracking Log) as well as facilitywide to analyze trends for Quality Assurance Reporting.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 01/31/13 with diagnoses of Difficulty in Walking, Generalized Muscle Weakness, Lack of Coordination, Personal History of Falls, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated 03/03/14 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact.</p> <p>Review of the quarterly MDS dated 11/06/13 revealed the facility assessed the resident to require supervision with transfers and ambulation.</p>	F 323			

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 16</p> <p>After the resident had a fall with injury on 11/30/13 the facility assessed via a significant change MDS dated 12/11/13 that the resident required extensive assistance with transfers and two (+) assistance with ambulation. The facility care planned the resident to be at risk for falls related to weakness, lack of coordination, difficulty walking, history of falls, history of back surgery, and chronic back pain.</p> <p>Review of the facility's Fall Tracking Log revealed Resident #9 experienced seven falls (without injury) at various times from 07/17/13 to 11/20/13. Documentation revealed staff evaluated the falls and developed interventions. On 11/30/13, at 2:00 PM, documentation revealed Resident #9 experienced a fall, and stated that he/she thought his/her "hip is broken." The facility transferred the resident to the Emergency Department (ED) and the resident was diagnosed to have a fractured hip. Continued review of the incident revealed facility staff determined the resident "had cane walking, fell back" as the "cause of fall."</p> <p>Continued review of the Falls Tracking Log revealed the resident experienced a fall on 02/03/14 at 6:40 PM and noted the resident "slid off the bed after an attempt to put self to bed." The facility noted the resident had an abrasion to the right side of the back and documented "slip strips" had been applied to the resident's bedside as an intervention. On 02/08/14 at 6:40 PM, documentation revealed Resident #9 experienced a fall when he/she "was going to get from w/c [wheelchair] and w/c moved." Documentation revealed the facility noted the wheels on the wheelchair were locked and asked for Maintenance to evaluate the wheelchair. Documentation on the fall log revealed on</p>	F 323			

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 17</p> <p>02/17/14 at 6:30 PM Resident #9 experienced a fall because he/she was "up from wheelchair attempting to get clothes from closet." The facility requested the resident "to ask for assistance when getting clothes from closet" as an intervention. Based on documentation on 03/11/14 at 6:20 PM, Resident #9 was observed "standing up with walker in sock feet." The facility "educated" the resident "not to get up without shoes on." On 03/17/14 at 7:35 PM, the facility noted the resident was "walking with walker" and "shoes just slipped." Documentation revealed staff observed a bruise on the resident's right arm, directed staff to "remind resident to use call light when needing assistance," and noted "non slip strips applied to floor." On 03/19/14 at 7:15 PM, staff documented Resident #9 reported he/she "got up to push my table and I just sat down." Documentation revealed the resident reported the "floor was slick," and that the facility inspected the floor and determined the floor was "not slick" and revealed safety strips were applied in front of the resident's chair. Continued review of the facility's Falls Tracking Log revealed all of the falls the resident sustained from 07/17/13 to 03/19/14 occurred in the resident's room.</p> <p>Although the facility identified causes of Resident #9's falls and developed interventions to address the falls, the facility failed to analyze trends related to the falls to ensure interventions were developed based on the analysis and/or assessment.</p> <p>Progress notes dated 04/07/14, revealed the facility discontinued the resident from the falls program and re-educated the resident on asking for assistance with transfers and ambulation.</p>	F 323			

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 18 Interview on 04/24/14 at 11:12 AM with Registered Nurse (RN) #2 revealed Resident #9 had experienced falls due to "getting up without assistance." The RN stated the facility tracks and trends falls and stated the facility discussed falls during the morning meetings. After a review of the falls Resident #9 had sustained after 11/30/13, RN #2 stated, "I hadn't realized that the [resident's] falls were happening right after dinner." Interview with the Director of Nursing (DON) on 04/24/14 at 4:45 PM revealed staff had informed Resident #9 to use a call light when he/she required assistance. The DON stated the facility had identified a pattern with the times of the resident's falls, and stated, "We encourage" the resident to use the restroom before and after meals. The DON stated Resident #9 "knows to not get up without help but does anyway." Interview with the Administrator on 04/24/14 at 12:00 PM revealed the facility maintained fall logs in order to track and trend resident falls. The Administrator stated the facility looked at the time of the day that Resident #9's falls occurred and what the resident was doing. After a review of the facility fall logs for Resident #9, the Administrator stated, "You can look at the tracking sheet and see a pattern but I couldn't tell you specific interventions being done for that pattern." The Administrator also stated staff had "talked" to the resident "several times" about asking for assistance and "calling out" before getting up, and stated the resident was "noncompliant."	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	F 328 04/24/14 RN Supervisor #1 changed oxygen to appropriate liter as ordered. F 328 Continued on next page.....		

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 328	<p>Continued From page 19</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of twenty-one (21) sampled residents received proper care and treatment related to oxygen administration (Residents #5). Resident #5 had physician's orders, dated 08/24/13, for 3 liters of oxygen per minute "as needed." However, observation on 04/22/14 and 04/23/14, revealed Resident #5's oxygen was in use and set at 2 liters per minute.</p> <p>The findings include:</p> <p>Interview with the Administrator on 04/24/14 at 4:28 PM revealed the facility did not have a specific policy related to the provision of oxygen or providing care in accordance with physician's orders. The Administrator stated care was provided in accordance with the standards of nursing practice protocols. However, the facility did not have written documentation of the nursing practice protocols for review.</p> <p>A review of Resident #5's medical record</p>	F 328	<p>F328 continuation.....</p> <p>04/24/14 all residents receiving oxygen were checked for appropriate oxygen settings.</p> <p>04/25/14 the Director of Nursing began inservicing nursing staff regarding the Nurse being responsible for setting the oxygen concentrators according to physician orders. The flow rate will be noted on the Medication Administration Record for the nurse to check every shift. The State Registered Nursing Assistants were in-serviced regarding checking concentrators to ensure that they are set according to the nurse aid care plan and to report any discrepancies immediately to the Nursing Supervisor.</p> <p>The Unit Coordinator will audit all residents on oxygen daily times 1 (one) week; then weekly times 2 (two) months; then quarterly times 1 (one) year to ensure the concentrators are set on the appropriate setting.</p> <p>Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.</p>	05/29/14

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 328	<p>Continued From page 20</p> <p>revealed the facility admitted Resident #5 on 04/23/07 with diagnoses that included Congestive Heart Failure, Hypertension, and Cardiomegaly. Continued review of Resident #5's record revealed a physician's order dated 08/27/13 for 3 liters of oxygen "per minute." Review of the Minimum Data Set (MDS) annual assessment dated 01/18/14 revealed the facility assessed Resident #5 to have a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was unable to be interviewed.</p> <p>Observations of Resident #5 on 04/22/14 at 3:17 PM and 3:54 PM, and on 04/23/14 at 9:17 AM, 11:40 AM, and 2:14 PM revealed oxygen was in use by the resident and set at 2 liters per minute.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on 04/23/14 at 3:28 PM revealed she did not know the rate at which Resident #5's oxygen was to be delivered and could not adjust the rate. According to the SRNA, she could review the resident's care plan to determine the rate at which the oxygen was to be delivered but only nurses could adjust the flow rate.</p> <p>Interview with State Registered Nurse Aide (SRNA) #5 on 04/23/14 at 3:37 PM revealed she had reviewed Resident #5's care plan on 04/23/14 and was aware of the rate at which the oxygen was to be administered. However, the SRNA stated she had failed to monitor the resident's oxygen rate on 04/22/14 and, as a result, failed to report the oxygen rate to the nurse.</p> <p>Interview with Registered Nurse (RN) #1 on 04/24/14 at 5:40 PM revealed staff could review the physician's orders and care plans to</p>	F 328			

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

PRINTED: 08/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 328	Continued From page 21 determine each resident's oxygen setting. RN #1 stated that nursing staff monitors each resident's oxygen in the mornings, checks their oxygen saturation, and reviews the Medication Administration Records (MARs). RN #1 stated she failed to identify Resident #5's oxygen was set at the wrong rate on 04/22/14.	F 328			
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation of the tray line on 04/22/14, beginning at 12:35 PM, revealed dietary staff touched an electric cord that was observed on the floor to the plate warmer with	F 371	F371 Dietary aide #1 was counseled regarding touching cord with her hands, wiping off counter and adjusting her waistband then returning to the tray line without washing her hands on 04/22/14. She was aware of her mistakes. She stated she was nervous having the surveyor watching her and acknowledged that she knew the hand washing policy and demonstrated proper procedure. All dietary staff were re-in-serviced regarding infection control and proper hand washing observation on 04/29/14. All new hires will be educated regarding proper hand washing and infection control procedures as well as annually thereafter. F 371 Continued on next page.....		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 371	<p>Continued From page 22</p> <p>bare hands and proceeded to serve food from the steam table without washing/sanitizing their hands; staff then proceeded to leave the tray line, obtained a wet dishcloth to clean spilled food products from the food preparation table, disposed of the dishcloth in the sink, adjusted the waistband of her pants, and proceeded to serve food from the tray line without washing/sanitizing her hands.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Environmental Sanitation/Infection Control," revealed employees involved in storing, preparing, distributing, and serving of food should wash their hands frequently using proper hand washing procedures to prevent food contamination and the spread of foodborne illness. The policy also revealed staff was required to wash/sanitize their hands when entering the kitchen from outside the kitchen, before and after food handling and preparation, after contact with soiled dishes and utensils, and after touching anything that can be a source of contamination.</p> <p>Observation of Dietary Aide #1 in the food preparation area of the kitchen on 04/22/14, at 12:35 PM, revealed the aide touched the electric cord lying on the floor to the plate warmer with her bare hands, and then proceeded to serve resident food trays from the serving line without washing/sanitizing her hands; Dietary Aide #1 was then observed to leave the tray line to obtain a wet dishcloth, cleaned spilled food from a food preparation table, disposed of the dishcloth in the sink, adjusted the waistband of her pants, and then proceeded to serve food from the tray line</p>	F 371	<p>F371 Continuation.....</p> <p>The Dietary Manager will monitor the staff during tray line daily alternating between breakfast, lunch and dinner for 2 (two) weeks; then weekly times 2 (two) months; then quarterly for 3 (three) quarters to ensure staff are following appropriate infection control and hand washing procedures.</p> <p>Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.</p>	05/09/14	

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
---	--

(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 371	<p>Continued From page 23 without washing/sanitizing her hands.</p> <p>Interview conducted with Dietary Aide #1 on 04/23/14, at 2:35 PM, revealed she was required to wash/sanitize her hands prior to serving food on the tray line, after touching any part of her body or clothes, and after cleaning the food preparation table. The Dietary Aide stated she should have also washed/sanitized her hands after touching the electric cord to the plate warmer. The Dietary Aide stated she had attended in-services provided by the facility on hand washing/sanitizing and was aware she should have washed/sanitized her hands anytime she stopped serving food from the tray line and prior to beginning to serve food again.</p> <p>Interview conducted with the Dietary Manager on 04/23/14, at 3:15 PM, revealed dietary staff was required to wash/sanitize their hands prior to serving food from the tray line and when they leave and return to the tray line for any reason. The Dietary Manager stated staff was also required to wash/sanitize their hands if they touched any surface such as the electric cord to the plate warmer, or the employee's clothing prior to beginning to serve food from the tray line. The Dietary Manager stated she monitored the tray line in the kitchen once a week to ensure staff washed their hands properly and had not identified any concerns.</p> <p>Interview conducted with the Registered Dietitian (RD) on 04/23/14, at 3:25 PM, revealed kitchen staff was required to wash/sanitize their hands prior to serving food from the tray line, any time they left the tray line for any reason, if the kitchen employee touched any surface such as the electric cord to the plate warmer, or if they</p>	F 371		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 371	Continued From page 24 touched their clothing or body. The RD stated the Dietary Manager had recently provided an in-service for kitchen staff related to hand washing and infection control. The RD stated she monitored one meal service every month at different meal times and had not identified any concerns with hand washing.	F 371			
F 441 SS=E	483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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	F 441	F441 State Registered Nursing Assistant #1 and #3 were re-educated on infection control regarding hand washing and food handling on 04/23/14. All residents on second floor dining room were monitored for signs and symptoms of infection for 2 (two) days. No infections related to improper hand washing at meal time was found. All State Registered Nursing Assistants were re-in-serviced by the Director of Nursing regarding handling of food when serving and hand washing during meal time; beginning on 04/24/14 and completed on 05/29/14. Infection control procedures will be reviewed with all nursing and dietary staff upon hire and annually thereafter. F441 Continued on next page.....		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 441	<p>Continued From page 25 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 by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection. Observation of the breakfast meal service on 04/23/14 in the second floor dining room revealed staff came into direct contact with food items with their ungloved hands and failed to wash/sanitize their hands prior to obtaining/touching the food items, or after serving the food items to residents.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Environmental Sanitation/Infection Control," not dated, revealed employees involved in storing, preparing, distributing, and serving of food were to wash their hands frequently using proper hand washing procedures to prevent food contamination and the spread of foodborne illness.</p> <p>A review of an in-service training record titled, "Hygiene and Sanitation," dated 04/02/14, revealed facility staff had discussed hand washing techniques and had been instructed on</p>	F 441	<p>F441 Continuation.....</p> <p>The Dietary Manager and Director of Nursing will observe staff performance during meal service to ensure that they are following proper food handling and hand washing procedures, alternating between breakfast, lunch and dinner daily times 1 (one) week then weekly times 1 (one) month then quarterly times 1 (one) year.</p> <p>Findings will be presented to the Quality Assurance Committee quarterly for 1 (one) year.</p>	05/29/14	

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 441	<p>Continued From page 28 importance and guidance.</p> <p>State Registered Nurse Aide (SRNA) #1 was observed during the breakfast meal service on 04/23/14, at 8:33 AM to feed a resident and then assisted another resident with their meal without washing/sanitizing her hands. SRNA #1 also touched a biscuit with his/her bare hands, served the biscuit to a resident and failed to wash his/her hands prior to or after serving the biscuit.</p> <p>Further observation revealed State Registered Nurse Aide (SRNA) #3 obtained bacon from the steam table with her bare hands and ate the bacon. SRNA #3 was not observed washing/sanitizing her hands prior to obtaining the bacon. At the time of the observation, 10 residents were observed in the dining room.</p> <p>Interview conducted with the Director of Nursing (DON) on 04/24/14, at 7:39 PM, revealed the facility conducted an in-service on safe handling of food the week of April 14, 2014, and observed meal services on a daily basis to ensure staff followed proper infection control measures. According to the DON, the facility had not identified any problems related to infection control during meal service.</p>	F 441			