



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

PRINTED: 12/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORFLEET DRIVE SOMERSET, KY 42601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	Submission of this response is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation.	
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 ensure services were provided in accordance with the Comprehensive Plan of Care for two (2) of nineteen (19) sampled residents related to toenail care (Resident #3 and Resident #4). Resident #3 and Resident #4's Comprehensive Care Plan contained care plan interventions for nail care to be provided by staff or a podiatrist; however, observations on 12/10/14 revealed nail care was not being provided for Residents #3 and #4.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy Statement," (not dated) revealed the Comprehensive Care Plan for each resident would be ongoing, and would be revised as information about the resident and the resident's condition changed.</p> <p>1. Review of Resident #4's medical record</p>	F 282	<p>F282</p> <p>Resident #3 and #4 were referred to the podiatrist who came on their next scheduled visit the following day, December 12, 2014. They were seen and their toenails were cut and treated.</p> <p>We have observed all residents' toenails. Any that were long, thick or jagged were trimmed, if possible, or an appointment was made with a local podiatrist immediately. A schedule has been instituted as to when the resident was last seen by the podiatrist and with the podiatrist, will devise a next visit date to ensure all residents are seen timely.</p> <p>The facility is now using a new weekly skin assessment form that is completed by the nurse. This assessment specifically list assessing the toenails, their thickness, and if they need trimmed, or if they are diabetic and may need a podiatrist consultation. For new admissions, all new residents will have a through assessment, including toenails. They will be referred to the podiatrist based on this assessment as needed. The facility will maintain a copy of the report of these visits.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gill Spurgeon TITLE: Adm. (X5) DATE: 1/6/15

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

From:

01/08/2015 13:51

#033 P.003/011

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

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F 282	<p>Continued From page 1</p> <p>revealed the facility admitted Resident #4 on 02/08/14 with diagnosis that included Hypertension, Dysphagia, Advanced Dementia, and Anxiety Disorder. Review of the Minimum Data Set (MDS) dated 08/31/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 1, which indicated the resident was severely impaired cognitively. Further review of the MDS revealed Resident #4 required extensive assistance with personal hygiene.</p> <p>Review of the Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Plan of Care updated on 12/05/14 revealed the resident would receive nail care every Sunday. Review of the Treatment Administration Record (TAR) dated 02/26/14 revealed Resident #4 would receive weekly skin assessments and nail care.</p> <p>Observation of Resident #4 on 12/10/14 at 11:15 AM during a skin assessment revealed Resident #4's toenails to be thick and long.</p> <p>Interview via phone with CNA #4 on 12/11/14 at 6:12 PM revealed CNA #4 noticed Resident #4's toenails were thick but did not notice that the toenails were long. She further stated it was on the CNA Care Plan to provide nail care.</p> <p>Interview with the Unit Manager on 12/11/14 at 6:20 PM revealed she conducted random spot checks on Mondays to ensure staff was following the care plans for the residents. She had not identified any problems with nail care.</p> <p>2. Review of the medical record revealed the facility admitted Resident #3 on 03/27/14 with diagnoses including Senile Dementia, Coronary Artery Disease, Hypertension, and Diabetes</p>	F 282	<p>The facility will monitor these assessments weekly by the Unit Managers. The Director of Nursing, Unit Managers, or other designees will randomly check at least 5 residents weekly, for 4 weeks, by observing their toenails for thickness, length, and any sign/symptoms of infection or pain. Any issues will be addressed immediately. The Director of Nursing will monitor the weekly skin assessments for any issues with the residents' toenails, and these also will be addressed immediately. Residents' toenails will be trimmed and monitor for thickness by facility staff wherever possible, and the facility will refer residents to the podiatrist as the situation warrants. The facility will review all weekly results in our facility Quality Assurance Committee meeting. Our Quality Assurance Committee consists of at least, the Administrator, the Director of Nursing, the Medical Director, Social Services and Activities, and other staff. We will review the findings of our weekly audits as well as the assessments of any new admissions and make recommendations as needed.</p> <p>Completion Date—12/31/14</p>		

From:

01/08/2015 13:52

#033 P.004/011

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F 282	<p>Continued From page 2 Mellitus - Type II.</p> <p>Review of the significant change comprehensive MDS assessment dated 09/30/14 revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognitive skills. In addition, the resident was assessed to require extensive assistance of staff for personal hygiene needs.</p> <p>Review of the comprehensive care plan revealed the facility addressed the potential for skin breakdown and foot care related to the resident's diagnosis of Diabetes Mellitus. Interventions included wearing appropriate footwear, weekly skin assessments and diabetic nail care, and a podiatry consultation and treatment as indicated.</p> <p>Resident #3 was observed sitting on the side of the bed eating dinner on 12/09/14, at 6:00 PM. The resident was not wearing shoes or socks and the resident's toenails were observed to be thick and long. Further observation during a skin assessment conducted with facility staff on 12/11/14, at 10:10 AM, revealed toenails on each of the resident's feet were very thick and long; the toenails on the third toe on each foot were noted to be grown over and almost touching the skin of the toe.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 12/11/14, at 6:00 PM, revealed the nurses were responsible to cut/trim the toenails of the diabetic residents. The LPN further stated if the resident's toenails were thick and long and staff was unable to trim, the resident should be referred to the podiatrist for evaluation and treatment. LPN #2 stated she had observed the</p>	F 282			

From:

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#033 P.005/011

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F 282	Continued From page 3 resident's toenails to be long and thick, but had never tried to cut the resident's toenails. LPN #2 stated she believed the resident was being seen by the podiatrist, but she had never reported the resident's thick, long toenails to the supervisor or the Social Services Director. Interview with Registered Nurse (RN) #1 revealed she was the Unit Manager for the C and D Halls and was responsible for ensuring resident care needs were provided in accordance with each resident's plan of care. The RN stated she conducted random "spot checks" to ensure the nurses were providing diabetic toenail care for residents; however, she had not observed Resident #3's toenails until 12/11/14.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to provide appropriate toenail care for one (1) of nineteen (19) sampled residents (Resident #4). Resident #4 was observed to have long, thick toenails on 12/10/14 at 11:15 AM. The findings include: Review of the facility's procedure titled "Assisting	F 312	F312 Resident #4 was referred to the podiatrist who came on their next scheduled visit the following day, December 12, 2014. She was seen and her toenails were cut and treated. We have observed all residents' toenails. Any that were long, thick or jagged were trimmed, if possible, or an appointment was made with a local podiatrist immediately. A schedule has been instituted as to when the resident was last seen by the podiatrist and the facility, along with the podiatrist, will devise a next visit date to ensure all residents are seen timely.	

From:

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#033 P.006/011

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F 312	<p>Continued From page 4</p> <p>with Foot Care," not dated, revealed toenails should only be trimmed by personnel qualified to do so according to facility policy. However, the facility does not have a policy for Activities of Daily Living (ADLs) and according to the Unit Manager the staff is to use the care plan as a guide.</p> <p>Review of Resident #4's medical record revealed the facility admitted Resident #4 on 02/06/14 with diagnoses that included Hypertension, Advanced Dementia, Dysphagia, and Anxiety Disorder. Review of the Minimum Data Set (MDS) assessment dated 08/31/14 revealed the facility assessed Resident #4 to be severely Impaired cognitively. Further review of the MDS revealed the facility assessed Resident #4 to require extensive assistance with personal hygiene. Review of the Treatment Administration Record (TAR) dated 02/26/14 revealed weekly skin assessments and nail care would be provided for Resident #4. Review of the Activities Daily Living (ADL) Plan of Care for the Certified Nurse Aide (CNA) revealed nail care was to be provided for Resident #4 every Sunday.</p> <p>Resident #4 was observed on 12/10/14 at 11:15 AM to have long, thick toenails on both feet. CNA #4 was interviewed on 12/11/14 at 6:12 PM (by phone). CNA #4 stated on 12/10/14, during the skin assessment and incontinence care, she noticed the resident's toenails were thick, but did not notice they were too long.</p> <p>Interview with the Unit Manager on 12/11/14 at 6:20 PM revealed the CNA staff does skin assessments on shower days and staff nurses do skin assessments weekly. On 12/11/14 at 6:30 PM in the resident's room, the Unit Manager</p>	F 312	<p>As of 1/6/15 the facility is using a new weekly skin assessment form that is completed by the nurse. This assessment specifically list assessing the toenails, their thickness, and if they need trimmed, or if they are diabetic and may need a podiatrist consultation. As of 1/6/15, all new residents will have a through assessment, including toenails. They will be referred to the podiatrist based on this assessment as needed. The facility will maintain a copy of the report of these visits.</p> <p>Beginning the week of 1/5/15, the facility will monitor these assessments weekly by the Unit Managers. The Director of Nursing, Unit Managers, or other designees will randomly check at least 5 residents weekly, for 4 weeks, beginning 1/5/15, by observing their toenails for thickness, length, and any sign/symptoms of infection or pain. Any issues will be addressed immediately. The Director of Nursing will monitor the weekly skin assessments for any issues with the residents' toenails, and these also will be addressed immediately. Residents' toenails will be trimmed and monitor for thickness by facility staff wherever possible, and the facility will refer residents to the podiatrist as the situation warrants. The facility will review all weekly results in our facility Quality Assurance Committee meeting. Our Quality Assurance Committee consists of at least, the Administrator, the Director of Nursing, the Medical Director, Social Services and Activities, and other staff. We will review the findings of our weekly audits as well as the assessments of any new admissions and make recommendations as needed.</p>		

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F 312	Continued From page 5	F 312	Completion Date—12/31/14		
F 328 SS=D	<p>stated she would not let a CNA cut Resident #4's toenails. The Unit Manager stated Resident #4 needed to be seen by a Podiatrist for nail care.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</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, record review, and facility policy review, the facility failed to ensure residents received proper diabetic foot treatment and care for one (1) of nineteen (19) sampled residents (Resident #3). Resident #3 was admitted to the facility with a diagnosis of diabetes mellitus and was observed to have long, thick toenails on both feet; however, there was no evidence foot care, including podiatry services, had been provided for the resident.</p> <p>The findings include: Review of the Skin and Foot Care policy (revision date April 2011) revealed toenails should only be trimmed by qualified personnel; either by regular staff or a podiatrist.</p>	F 328	<p>F328</p> <p>Resident #3 was referred to the podiatrist who came on their next scheduled visit the following day, December 12, 2014. She was seen and her toenails were cut and treated.</p> <p>We have observed all residents' toenails. Any that were long, thick or jagged were trimmed, if possible, or an appointment was made with a local podiatrist immediately. A schedule has been instituted as to when the resident was last seen by the podiatrist and the facility, along with the podiatrist, will devise a next visit date to ensure all residents are seen timely.</p> <p>As of 1/6/15 the facility is using a new weekly skin assessment form that is completed by the nurse. This assessment specifically list assessing the toenails, their thickness, and if they need trimmed, or if they are diabetic and may need a podiatrist consultation. As of 1/6/15, all new residents will have a through assessment, including toenails. They will be referred to the podiatrist based on this assessment as needed. The facility will maintain a copy of the report of these visits.</p>		

From:

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F 328	Continued From page 6 Resident #3 was observed sitting on the side of the bed eating dinner on 12/09/14, at 6:00 PM. The resident was not wearing shoes or socks and the resident's toenails were observed to be thick and long. Further observation during a skin assessment conducted with facility staff on 12/11/14, at 10:10 AM, revealed toenails on each of the resident's feet were very thick and long; the toenails on the third toe on each foot were noted to be grown over and almost touching the skin of the toe. Review of the medical record revealed the facility admitted Resident #3 on 03/27/14 with diagnoses including Senile Dementia, Coronary Artery Disease, Hypertension, and Diabetes Mellitus - Type II. Review of the significant change comprehensive MDS assessment dated 09/30/14 revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident to have severely impaired cognitive skills. In addition, the resident was assessed to require extensive assistance of staff for personal hygiene needs. Review of the comprehensive care plan revealed the facility addressed the potential for skin breakdown and foot care related to the resident's diagnosis of Diabetes Mellitus. Interventions included wearing appropriate footwear, weekly skin assessments and diabetic nail care, and a podiatry consultation and treatment as indicated. Interview conducted with the Social Services Director on 12/11/14, at 3:15 PM, revealed the nurses were responsible to assess the residents'	F 328	Beginning the week of 1/5/15, the facility will monitor these assessments weekly by the Unit Managers. The Director of Nursing, Unit Managers, or other designees will randomly check at least 5 residents weekly, for 4 weeks, beginning 1/5/15, by observing their toenails for thickness, length, and any sign/symptoms of infection or pain. Any issues will be addressed immediately. The Director of Nursing will monitor the weekly skin assessments for any issues with the residents' toenails, and these also will be addressed immediately. Residents' toenails will be trimmed and monitor for thickness by facility staff wherever possible, and the facility will refer residents to the podiatrist as the situation warrants. The facility will review all weekly results in our facility Quality Assurance Committee meeting. Our Quality Assurance Committee consists of at least, the Administrator, the Director of Nursing, the Medical Director, Social Services and Activities, and other staff. We will review the findings of our weekly audits as well as the assessments of any new admissions and make recommendations as needed. Completion Date—12/31/14		

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F 328	<p>Continued From page 7</p> <p>toenails and make the referrals to her and she would inform the podiatrist. The Social Services Director stated no one had told her about Resident #3's toenails and the resident had not been seen by the podiatrist.</p> <p>Interview with CNAs #2 and #3 on 12/11/14, at 5:35 PM revealed the CNAs could not recall ever looking at the resident's toenails when providing care for the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 12/11/14, at 6:00 PM, revealed she was routinely scheduled to conduct weekly head to toe skin assessments for Resident #3, including checking the resident's feet. LPN #2 stated she had observed the resident's toenails to be long and thick, but had never tried to cut the resident's toenails. LPN #2 stated she believed the resident was being seen by the podiatrist, but she had never reported the resident's thick, long toenails to the supervisor or the Social Services Director.</p> <p>Interview with Registered Nurse (RN) #1 on 12/11/14, at 6:10 PM, revealed she was the Unit Manager for the C and D Halls and was responsible for ensuring resident care needs were provided in accordance with each resident's plan of care. The RN stated she conducted random "spot checks" to ensure the nurses were providing diabetic toenail care for residents.</p> <p>Interview with the Director of Nursing (DON) on 12/11/14 at 6:20 PM, revealed the licensed nurse was responsible to trim/cut the diabetic residents' toenails or inform the Social Services Director so that a referral could be made to the podiatrist. The DON stated she had not observed Resident #3's toenails and was not aware the resident was</p>	F 328			

From:

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#033 P.010/011

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F 328	Continued From page 8 in need of podiatry services.	F 328			