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

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Division of Health Care
Southern Enforcement Branch

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185217		05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METCALFE HEALTH CARE CENTER	701 SKYLINE DRIVE EDMONTON, KY 42129

(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	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 282 SS=D	A standard health survey was conducted on 05/27-29/14. Deficient practice was identified with the highest scope and severity at "D" level. 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 facility policy review, the facility failed to ensure services were provided by qualified persons in accordance with the written plan of care for one (1) of fifteen (15) sampled residents (Resident #6). According to the plan of care, nail care would be provided weekly by facility staff; however, Resident #6 was observed to have long, thick, and jagged toenails. The findings include: Review of the facility's Care Plan Record policy (no date) revealed residents' daily care needs are to be provided by the nursing staff as outlined in the comprehensive care plan. Review of the medical record revealed the facility admitted Resident #6 on 08/01/13 with diagnoses including Dementia, Congestive Heart Failure, Mild Renal Insufficiency, Psychosis, and History of Deep Vein Thrombosis.	F 282	1. The toenails of resident #6 were trimmed by the nursing supervisor on 5/29/14. 2. The toenails and fingernails of all residents were inspected and trimmed as indicated by the house supervisor and charge nurses on 5/29/14. 3. The facility has contracted with podiatry services to provide toenail care/trimming for all residents on a monthly basis. Nursing staff have received in-service education on the newly contracted podiatry services and the need to inspect resident toenails with each bath/shower and to provide toenail care as indicated, or report the need for toenail care to the licensed nurse for residents with diabetes. 4. The CQI indicator for the monitoring of all resident care in accordance with the care plan, including but not limited to ADL care/ nail care, will be utilized monthly X 2 months, and then quarterly under the supervision of the DON. Findings from these indicators will be reviewed in the facility CQI meetings. ADL care, including but not limited to nail care, will be reviewed by the licensed nurses monthly with compliance rounds.	6/27/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Neighbors
TITLE: Administrator
(X6) DATE: 6/13/14

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

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F 282	Continued From page 1 Review of the quarterly Minimum Data Set (MDS) assessment dated 03/14/14, revealed the facility assessed Resident #6 to require total staff assistance with bathing and personal hygiene needs. Review of the comprehensive care plan dated 08/01/13 revealed the facility identified Resident #6 was unable to independently perform Activities of Daily Living (ADLs) due to impaired mobility and cognition. Interventions included encouraging the resident to participate as much as possible with ADL care and to provide nail care with shower or whirlpool schedule weekly and as needed. In addition, review of the Certified Nurse Aide (CNA) care plan record revealed nail care would be provided on bath days by the CNA. Observations during a skin assessment conducted with Licensed Practical Nurse (LPN) #1 on 05/28/14 at 11:00 AM, revealed the nails on the resident's great toe, second toe, and third toe of both feet were thick, long, and jagged. Interview with CNAs #1 and #2 on 05/29/14 at 1:50 PM, revealed they routinely provided care for Resident #6. The CNAs stated they were required to follow the resident's plan of care to provide nail care for the residents. CNAs #1 and #2 stated they had observed the resident's toenails to be long, thick, and jagged, and believed the treatment nurse was responsible to trim the resident's toenails when they were thick and long; however, the CNAs stated they had not reported this to the nurse. The CNAs stated they assumed the treatment nurse was aware of the condition of Resident #6's toenails. Interview with Licensed Practical Nurse (LPN) #1	F 282		

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F 282	Continued From page 2 on 05/29/14, at 2:00 PM, revealed she was the facility treatment nurse and was responsible to conduct weekly head to toe skin assessments for all residents. LPN #1 stated she was also responsible to perform nail care for the diabetic residents. The LPN stated the facility did not have a podiatrist who conducted routine visits at the facility. LPN #1 stated if a resident's nails could not be safely trimmed by facility staff, a podiatry consultation was obtained or a referral was made to the nurse practitioner who visited the facility weekly. However, LPN #1 stated a podiatry consultation or referral to the nurse practitioner had not been obtained for Resident #6. Interview with LPN #2 on 05/29/14 at 2:15 PM, revealed she was the Charge Nurse on West Hall and was responsible to ensure care needs were provided as directed by the resident's plan of care. LPN #2 stated the CNAs should report any concerns related to nail care for the residents to the nurses. The LPN stated she had not observed Resident #6's toenails and was not aware the resident's toenails were long, thick, and jagged. Interview with the Assistant Director of Nursing (ADON) on 05/29/14, at 3:45 PM, revealed the Director of Nursing (DON) was on vacation and not available for interview. The ADON stated there was no formal system to ensure care plan interventions were consistently implemented. The ADON stated nail care should be monitored during the bath and weekly skin assessments; however, the ADON stated no problems related to nail care had been reported.	F 282		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 3 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 facility policy review, the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for one of fifteen sampled residents (Resident #6). Staff failed to provide toenail care for Resident #6. The findings include: Interview with the ADON on 05/29/14, at 3:45 PM, revealed the facility did not have a specific policy related to toenail care for the residents. A review of the facility's procedure for Nail and Foot Care revealed nails would be easier to trim and clean right after soaking or bathing. The procedure directed that facility staff would not cut or trim toenails if the toenails were "very thick or ingrown." The procedure further noted the Registered Nurse (RN) or podiatrist would cut the toenails for these residents. Review of the medical record revealed the facility admitted Resident #6 on 08/01/13 with diagnoses including Dementia, Congestive Heart Failure, Mild Renal Insufficiency, Psychosis, and History of Deep Vein Thrombosis. Review of the quarterly Minimum Data Set (MDS)	F 312	1. The toenails of resident #6 were trimmed by the nursing supervisor on 5/29/14. 2. The toenails and fingernails of all residents were inspected and trimmed as indicated by the house supervisor and charge nurses on 5/29/14. 3. The facility has contracted with podiatry services to provide toenail care/trimming for all residents on a monthly basis. Nursing staff have received in-service education on the newly contracted podiatry services and the need to inspect resident toenails with each bath/shower and to provide toenail care as indicated, or report the need for toenail care to the licensed nurse for residents with diabetes. 4. The CQI indicator for the monitoring of all resident care in accordance with the care plan, including but not limited to ADL care/ nail care, will be utilized monthly X 2 months, and then quarterly under the supervision of the DON. Findings from these indicators will be reviewed in the facility CQI meetings. ADL care, including but not limited to nail care, will be reviewed by the licensed nurses monthly with compliance rounds.	6/27/14

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F 312	Continued From page 4 assessment dated 03/14/14, revealed the facility assessed Resident #6 to require total staff assistance with bathing and personal hygiene needs. Review of the comprehensive care plan dated 08/01/13 revealed nail care would be provided with the resident's shower or whirlpool schedule weekly and as needed. In addition, review of the Certified Nurse Aide (CNA) care plan record revealed nail care would be provided on bath days by the CNA. Observations conducted during a skin assessment on 05/28/14, at 11:00 AM with Licensed Practical Nurse (LPN) #1 revealed the toenails on Resident #6's great toe, second toe, and third toe of both feet were thick, long, and jagged. Interview with CNAs #1 and #2 on 05/29/14 at 1:50 PM, revealed they routinely provided care for Resident #6. CNAs #1 and #2 stated they had observed the resident's toenails to be long, thick, and jagged; the CNAs stated they had not reported this to the nurse. The CNAs stated they assumed the treatment nurse was aware of the condition of Resident #6's toenails. Interview with LPN #1 on 05/29/14, at 2:00 PM, revealed she was responsible to perform nail care for the diabetic residents. LPN #1 stated if a resident's nails could not be safely trimmed by facility staff, a podiatry consultation was obtained or a referral was made to the nurse practitioner who visited the facility weekly. However, LPN #1 stated a podiatry consultation or referral to the nurse practitioner had not been obtained for Resident #6. Interview with LPN #2 on 05/29/14 at 2:15 PM,	F 312		

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F 312	Continued From page 5 revealed she was the charge nurse on the West Hall and was responsible to ensure nail care was provided by either the nurse or the CNA routinely. LPN #2 stated the CNAs should report any concerns related to nail care for the residents to the nurses. The LPN stated she had not observed Resident #6's toenails and was not aware the resident's toenails were long, thick, and jagged. Interview with the Assistant Director of Nursing (ADON) on 05/29/14, at 3:45 PM, revealed nursing compliance rounds were conducted periodically to ensure nail care was provided for the residents. The ADON stated nail care should be provided by the CNAs or licensed nurse during the bath and/or weekly skin assessments. The ADON stated no problems related to nail care had been reported.	F 312		