

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

PRINTED: 10/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/24/2013
NAME OF PROVIDER OR SUPPLIER DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/24/13, as alleged.	{F 000}			

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

TITLE

(X6) DATE

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 000	INITIAL COMMENTS A recertification survey was conducted on 09/25/13 through 09/27/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest S/S of "E".	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure it maintained or enhanced each resident's dignity and respect for one resident (#10), in the selected sample of fourteen (14) residents. A Certified Nurse Aide (CNA) divulged Resident #10's personal identity and information in front of another resident (#19). The findings include:	F 241	DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.	
	Review of facility policy, titled "DIGNITY POLICY", last revised 06/01/12, revealed the facility provides care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The policy indicated dignity means that in their interactions with residents, the staff should carry out activities which assist the resident to maintain			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 10/22/13

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F 241	<p>Continued From page 1</p> <p>and enhance his or herself-esteem and self worth. The procedure section of the policy listed; "Do not talk loudly in corridors, nursing units, resident rooms and other areas about any resident".</p> <p>An observation, on 09/26/13 at 10:20 AM, revealed CNA #2 entered Resident #19's room while Licensed Practical Nurse (LPN) #3 was administering Resident #19's medication. CNA #2 stated to LPN #3 that Resident #10 (called the resident's name) "Wants an enema, he/she's been trying all morning to have a bowel movement. I've had him/her in and out of the bathroom and he/she just can't go".</p> <p>Interview with CNA #2, on 09/26/13 at 10:35 AM, revealed she had "made a mistake" by speaking of a resident in front of another resident.</p> <p>Interview with LPN #3, on 09/26/13 at 10:25 AM, revealed it was a privacy violation for CNA #2 to speak a resident's name and personal information in front of others. LPN #3 stated, "we have to constantly remind her".</p> <p>An interview with the Director of Nursing (DON), on 09/28/13 at 10:50 AM, revealed staff were not to talk about resident's personal information in front of others.</p>	F 241	<p>F 241</p> <p>1. Corrective action:</p> <p>Resident #10</p> <p>Psycho-social follow-up on 09-27-13 found Resident #10 to have no adverse effects from the divulged identity and information shared in the hearing of Resident #19. Resident #19, in an interview with the Social Services Director on 09-27-13 had no recall of the information about Resident #10.</p> <p>CNA #2 was re-educated on the Dignity Policy on 09-27-13 by the QA Nurse.</p> <p>2. ID of others at risk:</p> <p>A review of all residents was completed by the DON, QA Nurse and Social Services, on 10-15-13 with all interviewable residents indicating no problems with the transfer of private information and non-interviewable residents observed to be without issues.</p> <p>3. Prevention measures:</p> <p>In-service was held for all staff on 10-04-13 by DON regarding dignity, privacy, compliance and communication.</p>		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	F 441			

Additional page to 2567
Dawson Pointe, LLC
Provider # 185263
Survey Completed: 9/27/2013

2A

4. Monitor:

Privacy and communication will be monitored daily by Charge Nurses during Compliance Rounds; by the QA Nurse weekly x 4 weeks, then monthly x 3 months utilizing CQI tool. Any adverse findings will be corrected immediately and reported to the CQI Meeting monthly. (CQI tool IC-2 and Quality Assurance Round sheet)

5. Date Completed: 10-24-13

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F 441	<p>Continued From page 2</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy, it was determined the facility failed to ensure it maintained an infection control program to provide a safe, sanitary and comfortable environment to help prevent the</p>	F 441	<p>F 441</p> <p>1. Corrective action:</p> <p>LPN #3 was re-educated on the facility's Infection Control Policy, including proper hand washing on 09-27-13 by QA Nurse.</p> <p>Medication Tech #1 was re-educated on 09-27-13 by the QA Nurse on the facility's Infection Control Policy including the proper procedure regarding when a pill is dropped on the MAR.</p> <p>CNA #1 was re-educated on 09-27-13 by the QA Nurse on the facility's Infection Control Policy including the proper procedure for hand washing after touching a soiled item such as a clothing protector and proper sanitation techniques to use when serving meals or feeding residents.</p>	

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F 441	<p>Continued From page 3</p> <p>development and transmisslon of disease and infecllon. Observations revealed staff failed to appropriately wash or sanlize their hands during a meal service and during a medication pass.es.</p> <p>The findings include:</p> <p>A review of the facility's policy on medication adminstration titled, "INFECTION CONTROL, UNIVERSAL PRECAUTIONS" dated 03/09/10 revealed "Universal Precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status.</p> <p>1. An observation during a medication pass, on 09/26/13 at 10:10 AM, revealed Licensed Practical Nurse (LPN) #3 picked up a crumpled tissue with her bare hand from the floor on the 200 Hall. LPN #3 proceeded to walk to the medication room and retrieved a squirt container filled with applesauce. LPN #3 then went to the 300 Hall and placed the squirt container of applesauce on the medication cart that was located on the 300 Hall. LPN #3 failed to wash or sanllize her hands after picking up the crumpled tissue from the floor.</p> <p>An interview with LPN #3, on 09/26/13 at 10:25 AM, revealed she should have washed her hands after picking up the tissue from the floor but did not. She stated there was a potential for spreading disease and infection when proper handwashing was not utilized.</p> <p>2. An observallon of a medication pass, on 09/26/13 at 10:50 AM revealed Medication Techniclcn (MT) #1 dropped a pill on the Medication Administration Record (MAR) and</p>	F 441	<p>2. ID of others at risk:</p> <p>All residents may be affected by infection control techniques.</p> <p>3. Prevention measures:</p> <p>An in-service on Infection Control was held on 10-04-13 for all staff by the DON.</p> <p>4. Monitor:</p> <p>Monitor will be initiated for hand washing by the Charge Nurses during the Compliance Round Check 4 X daily. QA Nurse will monitor utilizing the CQI tool IC-2 weekly x 4 weeks and then monthly x 3 months. Any adverse findings will be corrected immediately and reviewed monthly by the facility's CQI Committee.</p> <p>5. Date Corrected:</p>	10-24-13	

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F 441	<p>Continued From page 4</p> <p>proceed to scoop of the pill with a medication cup, place the pill in applesauce and administer the pill to the resident.</p> <p>Interview with the MT #1, on 09/26/13 at 10:55 AM, revealed staff should call the Pharmacy and have another pill sent to the facility when a pill is dropped. MT #1 stated in hindsight she should have called the pharmacy because this was an infection control issue.</p> <p>3. Observation of the lunch meal in the main dining room, on 9/26/13 at 12:15 PM, revealed Certified Nursing Aide (CNA) #1 removed a soiled clothing protector from one (1) resident and failed to cleanse hands prior to serving a meal tray and feeding another resident.</p> <p>Interview with CNA #1, on 9/27/13 at 1:25 PM revealed he should have used sanitizer or washed his hands between serving each resident's meal tray.</p> <p>An interview with the Director of Nursing (DON, on 09/26/13 at 2:20 PM, revealed she expected staff to follow policy related to infection control and ensure they wash their hands appropriately.</p>	F 441		

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/24/2013 as alleged.	{K 000}			

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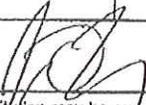


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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1962 Remodeled; 1971 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (211) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2008, with 35 smoke detectors and 32 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2007. EMERGENCY POWER: Type II Diesel Generator installed in 2007. A life safety code survey was initiated and concluded on 09/25/13. Dawson Pointe was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty-nine (59) beds with a census of fifty-three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction</p>	
K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.</p>	K 027		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 10/22/13

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K 027	<p>Continued From page 1</p> <p>Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure three (3) sets of cross-corridor doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:</p> <p>Observation, on 09/25/13 between 2:30 PM and 4:30 PM with the Maintenance Director, revealed the cross-corridor doors located on the 100, 200, and 300 halls would not close completely when tested, leaving a gap of approximately three (3) inches or greater between the pair of doors due to the door coordinators not functioning properly.</p> <p>Interview, on 09/25/13 between 2:30 PM and 4:30 PM with the Maintenance Director, revealed he was unaware the doors would not close all the way because he had been testing the doors only by releasing them from the magnets one time.</p>	K 027	<p>K 027</p> <p>1. Corrective action:</p> <p>Cross-corridor doors located on 100, 200, and 300 halls in the smoke barriers were adjusted by the Maintenance Department on 09-27-13 to ensure that the doors, when closed, had less than a 1/8" gap where the doors meet.</p> <p>2. ID of others at risk:</p> <p>Smoke compartments can affect all residents, staff and visitors. After repairs completed to the cross-corridor doors, no residents, staff or visitors are found to be at risk.</p> <p>3. Prevention measures:</p> <p>All corridor doors checked daily X 7 for proper closure ability by the Maintenance Department then continue weekly checks to assure all in proper working order.</p>	

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K 027	Continued From page 2 Reference: NFPA 101 (2000 edllion) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operallon and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edllion) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	4. Monitor: A review of the facility Life Safety Code compliance, including the working order of cross-corridor doors, will be monitored weekly by the Maintenance Department and findings reported through the facility CQI program.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure smoke compartments were properly evacuated in case of a fire. The findings include:	K 048	5. Date Completed:	10-24-13

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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
K 048	Continued From page 3 Fire Safety Plan review, on 09/25/13 at 4:30 PM with the Maintenance Director, revealed the facility's Fire Safety Plan and Procedure Policy failed to address the evacuation of smoke compartments in the facility. Interview, on 09/25/13 at 4:30 PM with the Maintenance Director, revealed he was unaware the evacuation of smoke compartments was not addressed on the fire safety plan. Further interview revealed the facility does address the evacuation of smoke compartments during their fire drills. Reference: NFPA 101 (2000 edition) Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff)	K 048	K 048 1. Corrective action: The facility Fire and Safety Plan was update on 10-14-13 to include the evacuation of smoke compartments. 2. ID of others at risk: Smoke compartments can affect all residents, staff and visitors. After repairs completed to the cross-corridor doors and update to the fire and safety plan, no residents, staff or visitors are found to be at risk. 3. Prevention measures: The Safety Committee updated the facility Fire and Safety Plan on 10-14-13 to include the evacuation of smoke compartments. All staff were in-serviced on the update 10/14-18/13 by the Maintenance Director and the DON. An update copy of the Fire and Safety Plan has been placed in the Business Office where the facility phone is managed and in each Department within the facility.	

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

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K 048	Continued From page 4 with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy 's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be	K 048	4. Monitor: Monitor will be initiated through the Fire and Safety CQI tool monthly and reviewed by the CQI Committee indefinitely. 5. Date Corrected:	10-24-13

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K 048	Continued From page 5 instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048		