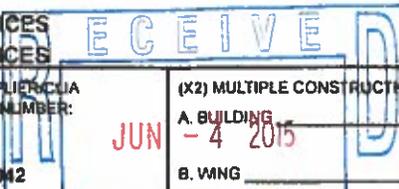


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1840 WATER TOWER BYPASS CAMPBELLVILLE, KY 42719
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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
F 000	INITIAL COMMENTS	F 000		
F 166 SS=D	<p>A standard health survey was conducted on 05/04/15 through 05/07/15. Deficient practice was identified with the highest scope and severity at "F" level.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of Interdisciplinary Care Plan Conference Minutes, it was determined the facility failed to resolve a grievance related to promptly answering call lights for one (1) of sixteen (16) sampled residents (Resident #4). Resident #4 verbalized a grievance to the Administrator during a care plan meeting, however, the Administrator failed to follow up and attempt to resolve the resident's grievance.</p> <p>The findings include: Review of the facility's policy titled "Filing Grievances/Complaints," dated 08/01/13, revealed a resident may orally or in writing file a grievance/complaint and the facility will investigate and inform the complainant of the findings of the investigation and actions that will be taken to correct any identified problems. Further review revealed the Administrator has the responsibility of investigating grievances and</p>	F 166	<p><i>The Grandview Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist. The Grandview Nursing and Rehabilitation reserves all rights to contest the survey findings through informal dispute resolutions administrative or legal resolutions administrative or legal proceedings. This plan of corrections does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard care, contract, obligation or position. The Grandview Nursing and Rehabilitation reserves all rights to raise all possible contentions and criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which The Grandview Nursing and Rehabilitation does not waive, reserves the right to assert in any administrative, civil or criminal claim action or proceeding. The Grandview Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to our residents'.</i></p> <p>F 166</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>It is and was on the day of survey the practice and policy of The Grandview Nursing and Rehabilitation to resolve grievances voiced by the resident.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cand. O'Brien* TITLE: *Administrator* (X6) DATE: *6-4-15*

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.

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F 166	Continued From page 1 complaints. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 06/23/09, with diagnoses of Depression, Hypertension, Peripheral Neuropathy, Cerebrovascular Disease, and Iron Deficiency Anemia. The facility assessed Resident #4 using the Minimum Data Set (MDS) dated 03/17/15 as having a Brief Interview for Mental Status (BIMS) score of 9 which indicates Resident #4 was moderately impaired cognitively. Further review of Resident #4's medical record revealed an Interdisciplinary Care Plan Conference was conducted on 03/10/15 at 11:30 AM, where a complaint was made by Resident #4 concerning his/her call light not being answered in a timely manner. An interview conducted on 05/04/15 at 7:20 PM with Resident #4 revealed he/she voiced concerns about call lights not being answered in a timely manner a few months ago in a care plan meeting but he/she was never told anything about the investigation or if any problem was identified by the facility. An interview with the Administrator on 05/07/15 at 9:30 AM revealed she remembered the grievance/complaint, and also discussed it with the Director of Nursing (DON), but failed to follow up and inform Resident #4 of any findings of the investigation.	F 166	<ol style="list-style-type: none"> Administrator and Social Service Director visited with Resident #4 on 5/7/15, to address the concern she voiced during a care conference meeting on 3/10/15 related to her call light not being answered timely. All care conference notes have been reviewed and no unresolved concerns/grievance were noted. All concerns/grievances voiced during a care conference meeting by resident/responsible party, will be written on a grievance report. This report will be forward to the Administrator and forward to the appropriate department to be addressed. Once the grievance has been addressed the form will be returned to the Administrator. On May 19, 2015, the care conference team was reeducated of the concern/grievances process and educated on the new care conference grievance form and given directions on how the form is to be used. All grievance reported will be follow up on for four weeks and reviewed in weekly care conference meeting. As part of the facilities ongoing Quality Assurance Program all grievances will be reviewed to assure satisfaction with resident/responsible party. 		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	<p>F 371</p> <p><u>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</u></p> <p>It is and was on the day of survey the policy and practice of the Grandview Nursing and Rehabilitation to store, prepare, distribute and serve food under sanitary conditions.</p>	6-4-15	

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F 371	<p>Continued From page 2 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions for seventy-six (76) of seventy-six (76) residents residing in the facility who received dietary trays from the kitchen. Observations on 05/05/15 revealed the following: an undated opened box of frozen pancakes in the freezer; staff serving food on the tray line coughed into their hand and continued serving food without changing gloves or washing/sanitizing their hands; the cook prepared fourteen (14) trays of food with only one gloved hand and touched the inside of plates with her bare hand; and staff dropped a tray card, picked it up from the floor, and continued to set up meal trays without washing or sanitizing their hands.</p> <p>The findings include: Review of the facility's policy titled "Employee Sanitary Practices," undated, revealed staff was required to use utensils or wear disposable gloves when necessary to handle food with their hands. The policy also revealed staff was not to cough, sneeze, or touch their hands to their mouth or face while serving food. The policy</p>	F 371	<ol style="list-style-type: none"> The sample and unsampled residents have not had any adverse effects related to the storing, preparing, distribution or serving of food. All open boxes of frozen and refrigerated foods have been checked for open dates. All dietary staff have been reeducated of dating foods when open and of the hand washing policy to prevent the transmission of bacteria. The Registered Dietitian will conduct an in-service on June 8, 2015, to address food storage, preparing, distribution and serving of food under sanitary conditions. The Dietary Manager or the Dietary Assistant Manager will check the freezer and refrigerator daily to ensure all open boxes have been dated. This practice will continue daily for the next month and then will be checked weekly by the Register Dietitian. As part of the facilities ongoing Quality Assurance Program the Dietary Manager will present a monthly report of the findings related to food storage, preparing, distribution and serving of food. 	6-9-15	

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F 371	<p>Continued From page 3</p> <p>stated if staff did, they were required to immediately wash/sanitize their hands after the occurrence. The policy revealed staff was required to follow hand washing policy and procedure.</p> <p>Review of the facility's policy titled "Leftover Foods," undated, revealed leftover cold foods should be dated and identified when placing back into the freezer.</p> <p>On 05/05/15 at 11:15 AM, the following observations were made in the kitchen: an undated opened box of frozen pancakes in the freezer; staff serving food on the tray line coughed into their hand and continued serving food without changing gloves or washing/sanitizing their hands; the cook prepared 14 trays of food with only one gloved hand and touched the inside of plates with her bare hand; staff dropped a tray card, picked it up from the floor, and continued to set up meal trays without washing or sanitizing their hands.</p> <p>Interview conducted with Dietary Aide #1 on 05/07/15, at 9:10 AM, revealed all opened packages of food were required to be labeled with the date they were opened. The Dietary Aide stated the package of pancakes had been previously opened when she obtained them from the freezer and she was unsure when they were opened.</p> <p>Interview conducted with Dietary Aide #2 on 05/07/15, at 9:13 AM, revealed she was aware she should have washed/sanitized her hands after dropping the tray card on the floor.</p> <p>Interview conducted with the Cook on 05/07/15,</p>	F 371			

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F 371	<p>Continued From page 4</p> <p>at 9:17 AM, revealed she was aware she should have been wearing gloves when serving food on the tray line.</p> <p>Interview conducted with the Dietary Manager on 05/07/15, at 9:20 AM, revealed she was responsible for ensuring the kitchen was sanitary. The Dietary Manager stated all foods were required to be labeled and dated prior to being placed in the freezer. The Dietary Manager stated staff was required to wash/sanitize their hands any time they dropped something and picked it up from the floor. In addition, the Dietary Manager stated any staff person that coughs/sneezes should wash/sanitize their hands and change gloves after the occurrence, and the Cook should have been wearing gloves when serving food from the tray line and touching food. The Dietary Manager stated she had not identified any concerns regarding sanitation prior to 05/05/15. The Dietary Manager stated she monitored meal service twice daily for any sanitation concerns.</p> <p>Interview conducted with the Registered Dietitian (RD) on 05/07/15 at 9:45 AM, revealed she monitored the kitchen with her weekly visits, and she had not identified any concerns with sanitation. The RD stated staff was required to wash/sanitize their hands any time they touched the floor, coughed, or sneezed into their hands. The RD stated the Cook should have been wearing gloves any time her hands were in contact with food. The RD stated all opened food packages should have been dated prior to being placed back into the refrigerator or freezer. The RD stated the Dietary Manger was responsible for monitoring to ensure all opened foods had been dated, and for any sanitation concerns.</p>	F 371			

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F 411 SS=E	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure four (4) of sixteen (16) sampled residents (Residents #3, #4, #7, and #10) had the opportunity to receive routine dental services to meet the needs of each resident. Review of the records for Residents #3, #4, #7, and #10 revealed no evidence that the residents received routine evaluation by a dentist.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Dental/Oral Examination Assessment," dated 08/01/13, revealed dental examinations would be made by the resident's personal dentist or by the facility's Consultant Dentist. However, the policy failed to identify how often a resident was required to be seen by a dentist.</p>	F 411	<p>F 411</p> <p><u>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</u></p> <p>It is and was on the day of survey the policy and practice of The Grandview Nursing and Rehabilitation to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident.</p> <ol style="list-style-type: none"> Nursing staff has completed an oral assessment for resident #3, #4, #7 and #10 and no dental referrals were needed at the time of assessment. The facility has a dental contract with Special Care Services. SCS will see all Medicaid resident once a year for a comprehensive exam and will see for certain focus problems monthly regardless of dental insurance coverage. Residents #3, #4 and #7 will be seen by SCS dentist on May 28, 2015. Resident #10 is private pay. Her POA does not want her to go see a dentist unless there is a problem. All residents have been reviewed for date of last dental visit. Information about Special Care Services Dental Services has been added to the admission packs. All new admissions will be asked to give the name of their preferred dentist and their last dental exam. A current census list and payor source list has been forward to Special Care Services so non dental insurance Medicaid residents can be added for a yearly comprehensive exam. The Social Service Director will review the dental list on a monthly basis prior to arranging a date for the dentist to visit. The Unit Coordinators will be responsible for asking the resident and/or responsible party of all private paid residents' if a dentist visit is desired. All residents' dental needs will continue to be reviewed quarterly and as needed. As part of the facilities ongoing Quality Assurance Program the Social Service Director will give a monthly update of all dental visits during Quality of Care Committee which includes the Administrator and Director of Nursing. 	6-12-15	

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F 411	<p>Continued From page 6</p> <p>1. Review of Resident #3's medical record revealed the facility admitted Resident #3 on 05/22/14 with diagnoses that included Muscle Weakness, Chronic Kidney Disease, End Stage Renal Disease, and Esophageal Reflux. The facility assessed Resident #3, in a Quarterly Minimum Data Set (MDS) dated 01/29/15, as requiring extensive assistance with hygiene. Review of Resident #3's care plan revealed the resident required assistance with oral care. Further review of the record revealed no documented evidence Resident #3 had been seen by or given the opportunity to be seen by a dentist.</p> <p>2. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 06/23/09 with diagnoses that included Depression, Hypertension, Cerebrovascular Disease, Peripheral Neuropathy, and Iron Deficiency. Review of an annual MDS assessment dated 11/11/14 revealed Resident #4 had no natural teeth. Review of the Care Plan revealed Resident #4 required assistance with oral care. However, review of the medical record revealed no documentation of a dental consultation or routine dental care.</p> <p>3. Review of Resident #7's medical record revealed the facility admitted Resident #7 on 12/31/13 with diagnoses that included Chronic Kidney Disease (Stage 3), Chronic Pain Syndrome, Cardiomegaly, Morbid Obesity, and Muscle Weakness. The facility assessed Resident #7 in a Quarterly MDS dated 02/17/15 to require extensive assistance with hygiene. Review of Resident #7's care plan revealed Resident #7 was edentulous. Further review of Resident #7's medical record revealed no</p>	F 411			

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F 411	Continued From page 7 documented evidence of routine dental care. 4. Review of Resident #10's medical record revealed the facility admitted the resident on 05/19/06 with diagnoses that included Scoliosis, Dementia, Depression, and Anxiety. Review of a quarterly MDS assessment dated 02/16/15 revealed Resident #10 required the extensive assistance of one person for personal hygiene. Review of Resident #10's medical record revealed no evidence of a dental consultation or routine dental care. Interview with the Social Worker on 05/06/15 at 1:30 PM revealed she was responsible for scheduling dental appointments for residents and was in the process of scheduling appointments. However, the Social Worker stated not all residents had been scheduled at this time. Interview conducted with the Director of Nursing (DON) on 05/06/15, at 1:50 PM, revealed the Social Worker was responsible for scheduling all dentist appointments and the Social Worker would schedule the resident for an appointment unless the resident or the family had refused. Interview conducted with the Administrator on 05/06/15, at 3:10 PM revealed the Social Worker was responsible for scheduling dental appointments for the residents. The Administrator stated he had not identified any concerns with residents not receiving routine dental care.	F 411		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE	F 514		

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F 514	<p>Continued From page 8</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to maintain an accurate clinical record for one (1) of sixteen (16) sampled residents (Resident #9). Review of the record for Resident #9 revealed a physician's order for Albuterol nebulizer treatments dated 01/31/15. Further review of the record revealed documentation that noted Resident #9 was allergic to Albuterol. However, interviews revealed the resident was not allergic to the medication as documented in the record and the facility failed to assure the resident's record was accurate.</p> <p>The findings include:</p> <p>Review of a facility policy titled "Medication Monitoring and Management," undated, revealed when a resident received a new medication the medication order would be evaluated for any known allergies to the medication, and if a</p>	F 514	<p>F 514</p> <p><u>483.75(l)(1) RESIDENT RECORDS- COMPLETE/ACCURATE, ACCESSIBLE</u></p> <p>It is and was on the day of survey the practice and policy of The Grandview Nursing and Rehabilitation to maintain clinical records on each resident in accordance with accepted professional stands and practices.</p> <ol style="list-style-type: none"> 1. Resident #9 medication and allergy list have been reviewed. The physician was notified and order received to remove the albuterol allergy as resident was not allergic to the medication but had experienced an adverse reaction to the medication. 2. As of June 4, 2015, all current residents' charts have been reviewed to compare current medications to allergy list. For the next two months the Director of Nursing and Unit Coordinator will review all new medication orders and compare to the residents allergy list. 3. The Director of Nursing has reeducated all nursing staff (LPN/RN's) of the general guidelines for medication administration and detecting adverse consequences which include reviewing the residents' allergies to new medication orders. An inservice with pharmacy has been scheduled for June 10, 2015 4. As part of the facilities ongoing Quality Assurance Program the Director of Nursing and Unit Coordinators will compare all new medication orders to resident's allergy listing to ensure competence of the nursing staff. This practice will continue for the next two months. If no additional problems are identified then the audits will be continues by pharmacy on a monthly basis. 	6-11-15	

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F 514	Continued From page 9 medication allergy was identified the physician would be notified. Interview conducted with Licensed Practical Nurse (LPN) #1 on 05/07/15 at 2:10 PM, revealed she was responsible for reviewing all monthly physician's orders for accuracy. The LPN stated she had not identified that Resident #9's record documented an allergy to Albuterol and that Resident #9 was receiving Albuterol. The LPN stated she should have notified the physician and sent a clarification order to the pharmacy. The LPN stated she had just missed the documentation of the allergy for Resident #9 for Albuterol. Interview conducted with Resident #9's physician on 05/07/15, at 3:05 PM, revealed Resident #9 had not had an allergic reaction to Albuterol, and instead had experienced an adverse reaction to the medication. The physician stated she had been aware of the allergy listed on Resident #9's medical record and Albuterol should not have been listed as an allergy for the resident. Interview conducted with the Director of Nursing on 05/07/15, at 2:46 PM, revealed with any new physician's order the nurse was required to review the order and to check for allergies. The DON stated LPN #1 was responsible for reviewing monthly physician's orders for accuracy and the error had just been missed.	F 514			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518	F 518 <u>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</u> It is and was on the day of survey the policy and practice of The Grandview Nursing and Rehabilitation to train all employees in emergency procedures and carry out unannounced staff drill using those procedures.		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2015
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 518	<p>Continued From page 10</p> <p>staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, facility in-service training, and facility policy review it was determined the facility failed to ensure all staff was trained in emergency preparedness related to tornados for ten (10) of twenty-one (21) staff members. Interviews with staff revealed ten (10) staff members (Certified Nurse Aides #1, #2, #3, #4, #5, and #6, Licensed Practical Nurse #2, Certified Medication Aide #1, Housekeeper #1, and the Facility Corporate Nurse Consultant) were unable to explain appropriate precautions to enact during a tornado warning.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "General Safety/Disaster Conditions, Tornados, or Severe Weather Disaster Policy," dated 04/01/13, revealed if a tornado warning was announced staff would move residents into the hallways behind fire doors. If this was not possible, the resident's bed would be moved from the windows to the center of the room, next to the beds by the inside doors.</p> <p>Review of the Emergency Preparedness Drills conducted by the Maintenance Supervisor on 03/10/15 and 04/29/15 revealed facility staff, from first and second shift, was trained on precautions to take in case of a tornado.</p> <p>Interviews with 21 staff members on 05/07/15</p>	F 518	<ol style="list-style-type: none"> The "Fire and Disaster Plan" had some updates on 8/30/2014. One of the updates was the tornado or severe weather disaster policy. The facility failed to replace the new policy in the "Fire and Disaster Plan" manual. The policy dated 4/1/2013, states <u>if the on-duty supervisor determines that the weather during a weather warning appears to be severe enough, some or all of the following procedures for a tornado emergency can be implemented. One of the procedures listed was to move the residents into the hallways behind the fire doors, in the bathroom, or along an inner wall without windows. If residents are in bed, pull the beds into the hallway. If this is not possible, move the beds from windows to the center of the room, next to the bed by the inside door.</u> The new policy dated 8/30/14, states <u>the on-duty supervisor takes charge, directs the overall emergency procedures and ensures that appropriate notifications are made. If the weather conditions appear to be severe enough, some or all of the following procedures may be implemented:</u> one of the producers listed related to moving the residents into the hall states.....<u>move all beds as close to the inner hallway wall as possible. If the rooms are semi-private, place the beds side-by-side as far over to the inner hallway as possible. If there is a tornado or severe weather warning, further precautions need to be take. Move ambulatory residents into the interior hallways behind fire doors, away from corners, windows, doors and exterior walls.</u> All ambulatory residents may be moved into the hall in the event of an actual tornado or they may stay in their room. If a resident stays in their room they will be moved away from the window as close to the hallway as possible with the cubical curtain closed. Bed bound residents will remain in their bed in their room with precautionary measures taken. This allows the hallways to be clear in the event of evacuation. No sampled or unsampled residents were affected by the change of policy. 		

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NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719	
(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 518	<p>Continued From page 11</p> <p>from 10:50 AM to 1:15 PM revealed 10 staff members, Certified Nurse Aides #1, #2, #3, #4, #5, and #6, Licensed Practical Nurse #2, Certified Medication Aide #1, Housekeeper #1, and the Facility Corporate Nurse Consultant stated the residents were to remain in their rooms during a tornado warning.</p> <p>Interview with the Maintenance Supervisor on 05/07/15 at 1:25 PM revealed staff was trained on Emergency Preparedness during their orientation and annually in the spring. He further stated during a drill only, staff was told to move the residents away from the windows; however, staff did not have to move them out into the hall. He stated he felt like staff was getting the drill instructions and the actual event of a tornado instructions confused.</p> <p>Interview with the Administrator on 05/07/15 at 1:35 PM, revealed the Maintenance Supervisor announced the tornado drill, "code black," over the intercom and the Administrator did a walk-through to ensure staff had the residents in the appropriate place in the facility. No issues or concerns had been identified with tornado drills.</p>	F 518	<p>3. All new employees are trained on emergency preparedness; including tornado watch/warning, procedures upon hire and annually in the spring. Each department has different job duties to perform during a drill/actual emergency. These department job duties are listed in the facilities "Fire and Disaster Plan" manual. All manuals have been correctly updated with the 8/30/2014 updates. All staff will be re-in serviced of the specific job duties during an emergency. This in-service will be conducted on June 18, 2015.</p> <p>4. As part of the facilities ongoing Quality Assurance Program the Maintenance Supervisor will conduct monthly tornado drills for the next three months following staff reeducation inservice scheduled for June 18, 2015. All results of the drills will be forward to the Administrator. If no issues are noted after the three months the facility will continue emergency preparedness training for all new hires during orientation and annually.</p>	6-19-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2015
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW A NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719		
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2004</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Two smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system installed in 2006, with 48 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 2006.</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted using a short form (2786S) on 05/05/15. The Grandview A Nursing and Rehabilitation Facility was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 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.