

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	
(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 AMENDED 08/05/13 corrected abbreviated survey number to KY #20214 A recertification/abbreviated survey (KY #20202 and KY #20214) was conducted on 05/29/13 through 05/31/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "D". KY #20202 and KY #20214 were substantiated with deficiencies cited.	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 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 one (1) resident (#20), not in the selected sample of seventeen (17) residents, was free from sexual abuse. A female resident (#12) who was cognitively impaired, and unsupervised, entered Resident #20's room and was found touching the resident's genitals.	F 223	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Criteria 1: -Resident # 20 was assessed on 5/13/13 to determine that he did not demonstrate any negative effects related to the reported event. the physician and responsible party were notified of the event. -A Velcro stop banner was on the entrance of the room of the resident # 20 to reduce the risk of residents entering without staff knowledge. -A transistor radio was placed on the wheelchair of resident #12 to assist staff to be alert to her location within the facility. -A psychiatric consult was obtained for resident #12. Criteria 2: -A review of the behavior observation documentation for the last 3 months was completed by the Interdisciplinary Care Plan	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Brown TITLE: N.H.A. (X6) DATE: 8-6-13

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 223	Continued From page 1 Findings include: Review of the facility's undated policy, titled "Policy and Procedure for Resident Abuses, Neglect, and Exploitation" revealed "Employees's are to ensure that all residents are protected from abuse, neglect, or exploitation. The supervisor will do a complete physical and mental assessment on the resident. Results of assessment will be noted in the resident's chart and turned in to the Director of Nursing (DON) and Administrator. All alleged actions involving abuse, neglect of exploitation must be reported immediately to your Supervisor or Administrator." Record review revealed Resident #20 was admitted to the facility with diagnoses to include Cerebral Vascular Accident, Right Sided Spasticity and Dementia, and Senile Dementia, Vascular Type. Review of Resident #20's annual Minimum Data Set (MDS) assessment, dated 2/21/13, revealed the facility assessed the resident with severe cognitive impairment and the resident was totally dependent on staff for anticipating and meeting all needs. Record review revealed Resident #12 was admitted to the facility with diagnoses to include Dementia with Behavior Disturbance and Impulse Control Disorder. Review of the quarterly MDS assessment, dated 05/17/13, revealed the facility assessed Resident #12 with severe cognitive impairment and the resident required assistance with all activities of daily living. Resident #12 was mobile per self via	F 223	F 223 Criteria 2, Continued team on 6/26/13 to identify resident behaviors which may present a risk for abuse. The team then reviewed/ revised the care plans for the identified residents to determine that the necessary abuse prevention interventions were documented and implemented. Criteria 3: -Inservice education was provided to the nursing staff on abuse, and the facility policy on abuse, including but not limited to the need to identify resident behaviors which may demonstrate the risk for abuse and the need to address the identified behaviors, as provided on 6/17/13, 6/18/13, and 6/19/13 by the DON/Staff Development Coordinator. Criteria 4: -The CQI indicator for the monitoring of compliance with the facility abuse policy will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator. Criteria 5: June 26, 2013.	

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F 223	<p>Continued From page 2</p> <p>reclining back wheelchair with foot rests removed. The resident had behaviors of wandering about the facility and into other residents rooms.</p> <p>Review of a Nursing Note, dated 05/12/13 at 5:50 AM, revealed Resident #12 was found in another resident's room and had his/her hands under the covers of the resident. Resident #12 responded "I was asked by him/her to help him/her pee". The resident was redirected with poor success.</p> <p>Review of the facility's investigation revealed on 05/12/13 at 5:50 AM, Resident #12 was observed in Resident #20's room with his/her hands in Resident #20's brief. Resident #12 was removed from Resident #20's room. The date the incident was reported was 05/13/13 at 7:15 AM.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #7, on 05/31/13 at 3:30 PM, revealed on 05/12/13 she came out of another resident's room and observed Resident #12 in Resident #20's room with his/her hand in Resident #20's brief, which was undone, and had the Resident 20's genitals in his/her hand. CNA #7 stated she removed Resident #12's hand from Resident #20's genitals. She stated Resident #20 did not appear to have any reaction to the incident.</p> <p>Interview with CNA #8, on 05/31/13 at 4:00 PM, revealed she observed Resident #12 in Resident #20's room on the morning of 05/12/13. Resident #12 had his/her hand in Resident #20's brief and was making movements of fondling Resident #20's genitals. CNA #8 stated Resident #20 did not appear to have any response to what was happening. Resident #12 was removed from Resident #20's room and redirected to the lobby area.</p>	F 223		

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F 223	Continued From page 3	F 223		
F 241 SS=D	<p>An interview conducted with the Director of Nursing (DON), on 05/30/13 at 4:45 PM, revealed Resident #12 should have been supervised to prevent the resident from entering the other resident's room.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide care in a manner and environment that maintained each residents dignity for six (6) residents (#12, #13, #14, #15, #16, and #17), in the selected sample of seventeen (17) residents, and five residents (#18, #19, #20, #21 and #22), not in the selected sample. Observation on 05/29/13 at 4:10 AM revealed Resident #12, #13, #14, #15, #16, #17, #18, #19, #20, #21 and #22 were up and dressed in the front lobby and in the hallway.</p> <p>Findings include:</p> <p>Observation on 05/29/13 at 4:10 AM revealed Resident #12, #13, #14, #15, #16, #17, #18, #19, #20, #21 and #22 were up and dressed in the front lobby and in the hallway.</p> <p>Interview with Certified Nurse Assistant (CNA) #4,</p>	F 241	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Criteria 1: -The Administrative nurses and Administrator reviewed the facility schedule for assisting the residents to rise in the morning for breakfast. The schedule was altered to begin assisting residents up from 5 am to 7 am in the morning.</p> <p>-Residents #12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 22 (or their responsible party if they were not interviewable) were interviewed by activity, social services or administrative nursing staff to determine their preferred time to rise in the morning. Those residents who preferred to get up before 5 am or after 7 am had this preference identified on their Care Plan and C.N.A. Care Plan.</p> <p>Criteria 2: -The Administrative nurses and Administrator reviewed the facility schedule for assisting the residents to rise in the morning for breakfast. The schedule was altered to begin assisting residents from 5 am to 7 am in the morning.</p> <p>-All residents (or their responsible</p>	

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F 241	<p>Continued From page 4</p> <p>on 05/29/13 at 5:20 AM, revealed staff start getting residents up between 4:00 AM and 4:30 AM because residents have to be ready for breakfast by 7:00 AM.</p> <p>Interview with CNA #3, on 05/29/13 at 6:45 AM, revealed staff start to get residents up at 4:00 AM or 4:30 AM. The CNA stated non-coherent residents and residents who are not in their right minds are assisted from bed first.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 05/29/13 at 6:00 AM, revealed staff don't get any residents up before 4:00 AM. The LPN stated even if they are short of staff we should not have any residents up before 4:00 AM. The LPN revealed staff have to have all residents up by 7:00 AM because the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said they have to be in the dining room sitting at the table by 7:00 AM. The LPN stated there are supposed to be six staff members on night shift but the last two weeks there have only been four staff. The LPN stated it was very hard to get everyone up by 7:00 AM and have them fully dressed and at the dining room table by 7:00 AM with less staff and some residents require two assist.</p> <p>Interview with Registered Nurse (RN) #1 Charge Nurse, on 05/29/13 at 4:35 AM, revealed a lot of residents want to go to bed after supper and they want to get up early. They eat supper at 5:00 PM and spend about nine hours in bed. Staff start getting the residents up about 4:00 AM or 4:30 AM.</p> <p>Interview with the ADON, on 05/31/13 at 4:30 PM, revealed staff start doing resident baths, getting</p>	F 241	<p>F241, Criteria 2, Continued</p> <p>party if they were not interviewable) were interviewed by activity, social services and administrative nursing to determine their preferred time to rise in the morning. Those residents who preferred to get up before 5 am or after 7 am had this preference identified on their Care Plan and Nurse Aide Care Plan.</p> <p>Criteria 3: -Facility nursing staff have received inservice education on the revised facility schedule for assisting residents up in the morning for breakfast, and the need to refer to the Care Plan/C.N.A. Care Plan for residents rising time preferences that are before 5 am or after 7 am, as provided on 6/17/13, 6/18/13, 6/19/13 and 6/20/13 by the DON and ADON.</p> <p>Criteria 4: -The CQI indicator for the monitoring of residents dignity, including but not limited to morning rising time, will be utilized monthly X 2 months and then quarterly thereafter, under the supervision of the Director of Social Services.</p> <p>Criteria 5: June 21, 2013.</p>		

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F 241	<p>Continued From page 5</p> <p>the residents ready and up to go to breakfast around 4:30 AM. The ADON stated we make the determination of when to get them up just like we do with other choices they can't make. All residents are up and ready to go to the dining room by 7:00 AM for breakfast. The CNAs are instructed to start their rounds at 4:30 AM. The ADON stated she did not know why residents were up at 4:10 AM. The ADON revealed the facility has to have a schedule. The CNAs are instructed to start baths and getting residents up at 4:30 AM. The ADON stated some residents go to bed after supper and have been in bed nine hours and are ready to get up.</p> <p>Interview with the DON, on 05/31/13 at 4:50 PM, revealed staff start at 4:30 AM or 4:45 AM to get residents out of bed. Resident's go to bed around 6:00 PM or 7:00 PM and start to get restless and want up. The majority of the residents want to be bathed and dressed before they go to breakfast. Their restless and awake and try to get out of bed. That's their way of telling the CNAs their ready to get up. We don't have a policy that says they have to be up and ready for breakfast. They want to be dressed and not in their night wear. After supper they are ready to go to bed. Supper is at 5:00 PM and by 6:00 PM their ready.</p> <p>Interview with the Administrator, on 05/31/13 at 5:10 PM, revealed a couple of staff called in sick so staff started earlier getting the residents up. The staff normally start at 4:30 AM. The Administrator stated staff try to get up as many residents as they can so the residents can go to the dining room to socialize and have breakfast.</p>	F 241			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas</p> <p>A standard Life Safety Code survey was conducted on 05/31/13. Barren County Health and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was ninety two (92) 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>	K 000		



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

Steve Brown

TITLE

N.H.H.

(X6) DATE

6-20-13

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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K 000	Continued From page 1	K 000		
K 038 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure exit doors and fire doors were maintained according to NFPA standards. This deficient practice affected eight (8) of eight (8) smoke compartments, staff and all the residents. The facility has the capacity for ninety four (94) beds with a census of ninety two (92) the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour conducted on 05/31/13 at 10:30 AM with the Administrator, a test of the magnetic door locks on the exit doors revealed the locks would reengage and not release while the fire alarm system was silenced and the fire alarm panel was still showing fire conditions. The locks should not reengage until the fire alarm system is reset and showing normal conditions. Further observation revealed the fire doors would reset to the open position while the</p>	K 038	<p>K 038 NFPA 101 Life Safety Code Standard.</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 & 19.2.1</p> <p>Criteria 1 - The magnetic door locks on the exit doors have been corrected by the vendor to assure that all exits doors do not reengage or reset while the fire alarm system is in the "silent" mode. The fire doors will not reset to open position until the fire alarm system has been "reset" and in the normal operating system.</p> <p>Criteria 2 - All exit doors were corrected on 6/5/13 as describe in Criteria 1.</p> <p>Criteria 3 - The Administrator received in-service education on 6/4/13 from the facility's contracted consultant on NFPA 101 (2000 Edition) Section 9.7 and Section 9.6.</p> <p>Criteria 4 - The QA Tool for monitoring life safety shall be utilized monthly X 2 and then quarterly as per the established QA calendar under the supervision of the Administrator.</p> <p>Criteria 5 - Completed 6/5/13.</p>	

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K 038	<p>Continued From page 2</p> <p>fire alarm panel was still showing fire conditions. The fire doors must not reset to the open position until the fire alarm system is reset and showing normal conditions.</p> <p>An interview with the Administrator, on 05/31/13 at 10:35 AM, revealed he was not aware these doors were not operating properly.</p> <p>Reference: NFPA 72 1999 edition</p> <p>3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.</p>	K 038			