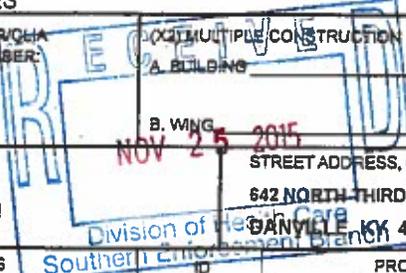


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE KY 40422		
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F 000 F 241 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 10/06-08/15. Deficient practice was identified with the highest scope and severity at "D" level.</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, interview, record review, and review of the facility's policy and procedure it was determined the facility failed to 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 for one (1) of twenty (20) sampled residents (Resident #2). A Certified Nursing Assistant (CNA) was observed for two (2) different meals to stand at bedside while feeding Resident #2.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Quality of Life-Dignity," revised 10/09, revealed each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality.</p> <p>Record review revealed the facility readmitted Resident #2 on 06/14/15 with diagnoses that included Chronic Obstructive Pulmonary Disease,</p>	F 000 F 241	<p>The following constitutes Danville Centre for Health and Rehabilitation's plan of correction for the deficiencies cited and will serve as the facilities credible allegation that compliance will be achieved on 11/13/15. However, submission of the plan of corrections is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with a claim or statement herein.</p>	



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

TITLE

(X6) DATE

[Signature]

Administrator

11-25-15

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 241	<p>Continued From page 1</p> <p>Anemia, Diabetes Mellitus, Depression, and Anxiety.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment dated 08/24/15 revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of 5, indicating the resident was not interviewable. Further review of the MDS assessment revealed the facility assessed the resident to require extensive assistance with eating.</p> <p>Observations on 10/08/15 at 12:55 PM and at 5:50 PM, revealed Certified Nursing Assistant (CNA) #2 was standing while assisting Resident #2 with his/her meal.</p> <p>Interview with CNA #2 on 10/08/15 at 3:30 PM, revealed she was trained to promote dignity while assisting residents with eating their meals. Further interview revealed CNA #2 stated she should have been seated and at eye level with Resident #2 while she fed the resident. CNA #2 further stated standing while feeding a resident could cause them to feel rushed and could cause them to not eat as well. CNA #2 stated she did not sit in a chair to feed the resident because she had back trouble and thought it would be easier to raise the bed and stand to feed the resident.</p> <p>Interview with the Director of Nursing on 10/08/15 at 6:15 PM, revealed the CNAs were taught to promote dignity with all care provided to the residents. The DON stated the CNAs should sit, maintain eye contact, and promote conversation while they assisted residents with their meals. The DON stated CNA #2 should have gotten someone else to feed Resident #2.</p>	F 241	<p>F241</p> <ol style="list-style-type: none"> 1.) On 10/9/15 Certified Nurse Aides feeding residents #2 was educated by the Director of Nursing not to stand when feeding residents. The staff feeding the resident listed above has been instructed by the Director of Nursing to sit with the residents in order to make eye contact and provide socialization while the resident is eating. 2.) On 10/9/15, all residents in both dining rooms as well as all residents receiving room service trays were observed by the Director of Nursing, Administrator, Assistant Director of Nursing and Unit Manager. During this observation no staff member was observed standing while feeding a resident. 3.) In-services will be performed by 11/13/15 by Director of Nursing and Administrator that stated the deficient practice (standing while feeding residents). The standard of care will be taught, at the in-service, to sit down when feeding a resident and making eye contact with them. The charge nurses will be instructed during this in-service to monitor on a daily basis for proper feeding of residents. 	11/13/15	

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of medication prescribing information it was determined the facility failed to meet professional standards of quality for one (1) of twenty (20) sampled residents (Resident #16). Resident #16 had physician orders for NovoLog Sliding Scale Insulin (fast acting insulin that should be administered before meals) every four (4) hours; however, observation on 10/07/15 at 9:10 AM, revealed the resident's NovoLog was administered after the breakfast meal.</p> <p>The findings include:</p> <p>Review of the Saunders Fundamentals of Nursing Manual, Second Edition, revealed medications had a great impact on the health and well-being of patients and the manufacture and use is highly regulated. This protected clients from harm and provides a common set of guidelines and standards to provide safe and effective medication therapy.</p> <p>Review of the "NovoLog Prescribing Information" dated 02/15, revealed NovoLog is a rapid acting insulin and should be administered immediately before a meal. Further review revealed hypoglycemia was the most common side effect of NovoLog. Additionally the prescriber information stated the timing of meals could decrease the risk of hypoglycemia.</p>	F 281	<p>4.) An audit concerning the dignity of residents will be conducted by the Director of Nursing, Assistant Director of Nursing and Unit Manager to assure staff is sitting when feeding or assisting a resident to eat. This audit will be conducted daily x 1 week, then weekly x 4 weeks and then monthly for 3 months, then quarterly x 2 months to ensure 100% compliance is being achieved. This audit will be conducted as part of the facility Quality Assurance and Performance Improvement Program.</p> <p>F281</p> <p>1.) Resident # 16 was not negatively affected by the deficient practice. RN administering medication outside of timeframe was counseled by the Director of Nursing on 10/9/15 regarding medication administration guidelines. The Nurse Practitioner for resident #16 was contacted by the Assistant Director of Nursing and a new order was obtained to clarify insulin sliding scale as resident is a brittle diabetic. Insulin accuchecks MD order was changed from every four hours to every four hours and with meals and two PO medications were changed as well on 10/12/15.</p>	11/13/15

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F 281	<p>Continued From page 3</p> <p>Record review revealed the facility admitted Resident #16 on 07/24/15 with diagnoses that included Diabetes Type 1-Insulin Dependent, Hypertension, and Anxiety.</p> <p>Review of an Initial Minimum Data Set (MDS) assessment dated 07/31/15 revealed the facility assessed Resident #16's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident was interviewable.</p> <p>Review of a Physician's Order dated 10/01/15 through 10/31/15 revealed an order for Accuchecks (blood glucose monitoring) every four hours daily and an order for NovoLog 100 units/milliliter (U/ml) to be injected per sliding scale directions every four hours. The sliding scale order was as follows: if the blood sugar level was 60-150 milligrams per deciliter (mg/dL), administer zero (0) units of insulin; 151-200 mg/dL, administer 4 units of insulin; 201-250 mg/dL, administer 6 units of insulin; 251-300 mg/dL administer 8 units of insulin; 301-350 mg/dL administer 10 units; 351-400 mg/dL administer 12 units of insulin; and 401-500 mg/dL, administer 14 units of insulin and call the physician.</p> <p>Observation of an Accucheck, medication pass, and interview with Resident #16 on 10/07/15 at 9:10 AM, revealed Resident #16's blood sugar was 362 mg/dL. Further observation revealed Registered Nurse (RN) #3 administered 12 units of NovoLog per the sliding scale order. Interview with Resident #16 revealed he/she had breakfast over an hour ago.</p>	F 281	<p>2.) Any resident that receives insulin have the potential to be affected. On 10-9-15 all residents that receive insulin were assessed by the Director of Nursing, Assistant Director of Nursing and Unit Manager to determine if proper procedure is used when checking and administering insulin. All residents assessed had an accurate order or insulin administration and parameters in place to ensure proper accucheck times and insulin administration in accordance with policy guidelines.</p> <p>3.) The Registered Nurse was counseled on 10/9/15 regarding deficient practice regarding insulin administration. All licensed staff will be educated on insulin administration as it relates to accurate and timely accuchecks and administration times of insulin administration. If sliding scale insulin is to be administered after a meal the nurse will contact the physician prior to administration. This education will be completed by 11/13/15.</p> <p>4.) Audits of the medication pass regarding accuchecks and sliding scale insulin administration will be conducted weekly x 4 weeks, then monthly x 3 months, then</p>		

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F 281	Continued From page 4 Interview with RN #3 on 10/07/15 at 3:20 PM, revealed she had administered the NovoLog after the substantial meal and was taught as a nurse to always administer fast acting insulin just before a substantial meal to prevent the risk of hypoglycemia (blood sugar decreases to below normal level). RN #3 stated although the order did not state specifically to give before meals she knew it was the standard of practice. Interview with the Director of Nursing on 10/08/15 at 6:15 PM, revealed she expected nurses to administer medications according to the accepted guidelines. Interview with the Advanced Practice Registered Nurse (APRN) on 10/07/15 at 10:05 AM, revealed sliding scale insulin should be given before a substantial meal because its purpose was to work with the food eaten during the meal to prevent excessive spikes in blood sugar. The APRN stated obtaining an Accucheck after a substantial meal could also result in the administration of unnecessary amounts of insulin because the blood sugar normally spikes from one to three hours after a meal.	F 281	quarterly x 2 by the Director of Nursing or designee to ensure compliance. All findings will be reported to the Director of Nursing Services. The Director of Nursing Services will report finding at Quality Assurance and Performance Improvement Meetings.	
F 282 SS=D	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,	F 282	1.) Residents #3, #8 and #12 care plans were reviewed and updated by a licensed nurse. The physician was notified on 10/9/15 by the Assistant Director of Nursing for resident #3 and the continuous oxygen order was discontinued and removed from the care plan to reflect new physician order of no oxygen. Residents #8 and #12 were reviewed with no changes made at this time.	11/13/15

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F 282	<p>Continued From page 5</p> <p>and review of facility policy it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for three (3) of twenty (20) sampled residents (Resident #3, Resident #8, and Resident #12). Resident #3's Comprehensive Care Plan contained interventions that included oxygen at two (2) liters per minute (L/min) continuously. However, observations on 10/06/15, 10/07/15, and 10/08/15 revealed Resident #3's oxygen to not be in use. Resident #8's Comprehensive Care Plan contained interventions that included use of one-quarter side rails as an enabler. Observations on 10/06/15, 10/07/15, and 10/08/15 revealed Resident #8 to not have one-quarter side rails in use. Resident #12's Comprehensive Care Plan contained interventions to "prevent tension on urinary meatus from catheter." However, record review and interview revealed Resident #12 had a skin tear to the urinary meatus (opening of the urinary tract) on 05/25/15 and the catheter was not anchored to prevent tension per the plan of care.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Care Plans - Comprehensive," dated October 2010, revealed the care plan will be reviewed as needed to reflect the resident's current needs, when there had been a significant change in condition, when the desired outcome was not met, when the resident had been readmitted from a hospital stay, and at least quarterly. Further review of the policy revealed the purpose of the care plan was to incorporate identified problem areas, incorporate risk factors associated with identified problems, and reflect currently recognized standards of practice for problem areas and</p>	F 282	<p>2.) The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Manager will complete and document an audit of care plans for current residents by 11/6/15 to determine that care is provided in accordance with the care plan. Any concerns identified will be correct at that time.</p> <p>3.) The Director of Nursing, Assistant Director of Nursing, Unit Manager and Administrator will re-educate licensed nurses to the care plan policy and guidelines for initiating and updating care plans and providing care in accordance with the care plan by 11/13/15.</p> <p>4.) The Director of Nursing, Assistant Director of Nursing and Unit Manager will document an audit of 10 care plans per week x 4 weeks, 10 per month x 2 months and 10 per quarter x 2 quarters to determine that care is being provided in accordance with the care plan. Any concerns identified will be corrected at that time. The Director of Nursing will submit a summary of findings each to the Quality Assurance and Performance Improvement Committee monthly x 3 months and then at least quarterly x 2 months for further review and recommendations.</p>	

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F 282	<p>Continued From page 6</p> <p>conditions. Further review of the policy revealed no guidance to staff in following the plan of care.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted Resident #3 on 05/08/13 with diagnoses that included Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Recurrent Pneumonia, Hypertension, and Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated 08/09/15 revealed the facility assessed Resident #3 to require the use of oxygen. Furthermore the facility assessed Resident #3's Brief Interview for Mental Status (BIMS) score to be 6 indicating severe cognitive impairment. Review of the physician's order dated 08/02/15 revealed Resident #3 had an order to use oxygen at 2 L/min via nasal cannula continuously. Review of the Comprehensive Care Plan dated 08/02/15 revealed Resident #3 to have care plan interventions for oxygen per doctor's order.</p> <p>Observations on 10/06/15 at 12:05 PM, 12:30 PM, 12:50 PM, 3:05 PM, 4:30 PM, and 5:40 PM, on 10/07/15 at 9:10 AM, 10:10 AM, 10:55 AM, and 12:10 PM, and on 10/08/15 at 9:30 AM revealed Resident #3 to not have oxygen in use.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 10/07/15 at 11:00 AM revealed she thought the order for Resident #3's oxygen was as needed and not continuous and that it was kept in the room in case the resident needed it. She also stated that Resident #3 often takes his/her oxygen off and throws it on the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/07/15 at 12:15 PM revealed she was responsible for Resident #3's care. She stated</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>that she thought Resident #3's order for oxygen was as needed, not for continuous. She looked at the physician's order on the computer and stated it does show the resident is ordered oxygen at 2 L/min per nasal cannula continuously. Furthermore, she stated that the resident takes off his/her oxygen and will not keep it on. She stated that the nurse caring for the resident is responsible for making sure that their oxygen is on as ordered.</p> <p>Interview with the Director of Nursing (DON) on 10/08/15 at 10:10 AM revealed she thought Resident #3's order for oxygen was PRN (as needed). She stated that his/her oxygen saturation has been good for a while now. She stated the resident takes the oxygen off and throws it on the floor and is noncompliant with use.</p> <p>2. Review of Resident #8's medical record revealed the facility admitted Resident #8 on 03/28/12 with diagnoses that included Chronic Obstructive Pulmonary Disease, Breast Cancer with metastases to the lungs, Dementia, Anxiety, Psychosis, Paranoid Schizophrenia, Chronic Pain, Dementia, and Crohn's Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated 09/11/15 revealed the resident's BIMS score was 10 which indicated moderate cognitive impairment. Review of the physician's order dated 04/06/15 revealed Resident #8 had an order for one-quarter side rails to bed to use as an enabler. Review of the Comprehensive Care Plan dated 03/25/15 revealed Resident #8 to have care plan interventions for one-quarter side rails to be used as an enabler.</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>Observations of Resident #8 on 10/06/15 at 4:30 PM, 10/07/15 at 10:10 AM and 11:00 AM, and 10/08/15 at 9:35 AM revealed one-quarter side rails to not be in use.</p> <p>Interview with Resident #8 on 10/08/15 at 1:40 PM revealed the resident does use the one-quarter side rails to turn in bed or to assist the resident to pull up into a sitting position when in bed. The resident also stated he/she has moved the side rails up and down occasionally, but could not remember the last time he/she had done so.</p> <p>Interview with CNA #1 on 10/07/15 at 11:00 AM revealed she was not aware that Resident #8 was supposed to have his/her one-quarter side rails up to use as an enabler. She stated that she finds out what care the residents need by the CNA care plan and when the nurse responsible for the resident tells the CNAs.</p> <p>Interview with the Director of Nursing (DON) on 10/08/15 at 10:10 AM revealed she was aware of Resident #8's order for one-quarter side rail use as an enabler, but the resident could put them up and down on his/her own. She also stated that it was the nurse's responsibility to make sure the residents receive the proper treatments, including oxygen therapy and side rail use.</p> <p>3. Observation of wound care and a skin assessment was attempted for Resident #12 on 10/08/15 at 1:10 PM. However, Resident #12 refused to have the observation made by a surveyor.</p> <p>Review of Resident #12's record revealed the facility admitted Resident #12 on 05/27/14 with</p>	F 282		

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F 282	<p>Continued From page 9</p> <p>diagnoses that include Right Above the Knee Amputation, Anemia, Gangrene Right Lower Extremity, Hypertension, Gastroesophageal Reflux Disease, Hyperlipidemia, Hemiplegia, Peripheral Vascular Disease, Diabetes Mellitus Type II, Alzheimer's Disease, Idiopathic Peripheral Neuropathy, Convulsions, Joint Contractures, and Pressure Ulcers. Review of Resident #12's most recent Quarterly Minimum Data Set (MDS) assessment dated 08/19/15 revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of 4 which indicated Resident #12 was severely impaired cognitively. Continued review of Resident #12's MDS assessment revealed the facility assessed Resident #12 to have an indwelling urinary catheter. Further review of the MDS assessment revealed Resident #12 had impairment in functional limitation in range of motion on both sides to his/her upper extremities. Review of Resident #12's Nurse Aide Care Plan, undated, revealed an intervention to assure that Resident #12's indwelling urinary catheter was secured to a leg strap or bed linens. Review of Resident #12's Comprehensive Care Plan dated 08/03/14 revealed Resident #12 had potential risk for complications related to his/her urinary catheter with an intervention dated 09/24/14 to prevent tension on the urinary meatus (external opening at the end of urinary tract) from the catheter.</p> <p>Continued review of Resident #12's record revealed a Nursing Assessment dated 05/25/15 indicating that during a bath, staff identified Resident #12 to have a skin tear on the foreskin of the penis. Continued review of the Nursing Assessment revealed the skin tear had been caused by irritation of the catheter tubing.</p>	F 282			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
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F 282	<p>Continued From page 10</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 10/08/15 at 1:41 PM revealed she was the nurse who had discovered the skin tear on Resident #12 on 05/25/15. Continued interview with LPN #2 revealed Resident #12's urinary catheter was leaking and when she pulled Resident #12's foreskin back she noticed an open area on the penis. LPN #2 further stated that all urinary catheters should be anchored either with a leg strap or by being clipped to the bed linens. LPN #2 stated that Resident #12's urinary catheter was not secured at the time she discovered the skin tear to Resident #12's foreskin.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 10/08/15 at 2:19 PM revealed she provided catheter care for Resident #12 in the past and had never noticed the catheter to not be anchored. Continued interview with SRNA #3 revealed Resident #12 had a leg strap that was used to anchor his/her catheter. SRNA #3 stated she had noticed the leg strap to be slipped off in the past. Continued interview with SRNA #3 revealed it was facility policy for all catheters to be anchored with a leg strap or clipped to the resident's bed linens.</p> <p>Interview with Registered Nurse (RN) #1 on 10/08/15 at 2:33 PM revealed all catheters were to be anchored by a leg strap or clipped to the sheets. Continued interview with RN #1 revealed she was not aware of any reason why an indwelling urinary catheter would not be anchored. Continued interview with RN #1 revealed Resident #12 had refused to wear a leg strap to anchor his/her catheter in the past. Further interview with RN #1 revealed it was the</p>	F 282		

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F 282	<p>Continued From page 11</p> <p>responsibility of all nursing staff to ensure that urinary catheters were anchored and that it was facility policy for all catheters to be anchored.</p> <p>Interview with the Unit Manager (UM) for Unit Two on 10/08/15 at 2:50 PM revealed Resident #12 had a leg strap to anchor his/her catheter and she was not sure if Resident #12's urinary catheter had been anchored when the skin tear was discovered on 05/25/15. Continued interview with the UM revealed the facility policy was that all catheters were to be anchored with a leg strap or clipped to the resident's bed linens and she was not aware of any reason why a catheter was not anchored. Further interview with the UM revealed it was the responsibility of all nursing staff to ensure that indwelling urinary catheters were anchored.</p> <p>Interview with the facility Director of Nursing (DON) on 10/08/15 at 5:46 PM revealed she had observed Resident #12 to pull on his/her leg strap in the past and had also observed him/her to take the leg strap off in the past. Continued interview with the DON revealed that facility policy was that all catheters were to be anchored using either a leg strap or by clipping the catheter tubing to the resident's bed linens. Continued interview with the DON revealed she was unsure if Resident #12's catheter was anchored on 05/25/15 at the time the skin tear was discovered. Further interview with the DON revealed it was the responsibility of all nursing staff to ensure that indwelling urinary catheters were anchored. The DON revealed that she conducted daily walking rounds and was unaware of any concerns related to care plans not being followed related to urinary catheters not being anchored.</p>	F 282			

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F 315 F 315 SS=D	Continued From page 12 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined that the facility failed to provide adequate care to prevent injury related to the use of an indwelling urinary catheter for one (1) of twenty (20) sampled residents (Resident #12). Resident #12's Comprehensive Care Plan dated 08/03/14 had an intervention to prevent tension from the urinary catheter. On 05/25/15, Resident #12 was identified to have a skin tear to the foreskin due to his/her indwelling urinary catheter not being anchored. The findings include: Review of facility policy titled "Catheterization Care," undated, revealed that once catheter care was performed the catheter securement device was to be reapplied and slack was to be left in the tubing so that movement did not create tension on the catheter. Review of Resident #12's record revealed the	F 315 F 315	F315 1.) A leg band already in placed on resident #12 to anchor the tubing of his catheter in an effort to avoid trauma/pain/tension and to allow for proper drainage on 5/27/15. On 8/24/15 a different style of leg band was provided to resident #12 as he did not like the current type. 2.) A catheter listing was pulled from the Physician Order List which showed all residents who have catheters in the building. All residents on the list were checked for proper anchoring of the catheter tubing by use of a leg band. The process has been repeated on four different occasions since 10/9/15 and all residents on the list had the necessary leg bands in place. 3.) An order for a leg band to be applied to the tubing of a foley catheter for proper anchoring will be added to the electronic TARS. The Licensed Nurse will observe the leg band for proper anchoring prior to signing the TAR. Any identified problems will be addressed immediately and then reported to the Director of	11/13/15

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F 315	Continued From page 13 facility admitted Resident #12 on 05/27/14 with diagnoses that include Right Above the Knee Amputation, Anemia, Gangrene Right Lower Extremity, Hypertension, Gastroesophageal Reflux Disease, Hyperlipidemia, Hemiplegia, Peripheral Vascular Disease, Diabetes Mellitus Type II, Alzheimer's Disease, Idiopathic Peripheral Neuropathy, Convulsions, Joint Contractures, and Pressure Ulcers. Review of Resident #12's most recent Quarterly Minimum Data Set (MDS) assessment dated 08/19/15 revealed the facility had assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of 4 which indicated Resident #12 to be severely impaired cognitively. Continued review of Resident #12's MDS assessment revealed the facility assessed Resident #12 to have an indwelling urinary catheter. Further review of Resident #12's MDS assessment revealed the facility had assessed Resident #12 to have Impairment in functional limitation in range of motion on both sides to his/her upper extremities. Review of Resident #12's Nurse Aide Care Plan, undated, revealed an intervention to assure that Resident #12's indwelling urinary catheter was secured to a leg strap or the bed linens. Review of Resident #12's Comprehensive Care Plan dated 08/03/14 revealed Resident #12 had potential risk for complications related to his/her urinary catheter and an intervention dated 09/24/14 to prevent tension on the urinary meatus (external opening at the end of urinary tract) from the catheter. Continued review of Resident #12's record revealed a Nursing Assessment dated 05/25/15 indicating that during a bath staff had identified Resident #12 to have a skin tear on the foreskin of the penis. Continued review of the Nursing Assessment revealed the skin tear had been caused by irritation from the catheter tubing.	F 315	Nursing or designee for follow-up. All licensed staff will be educated in the importance of providing a leg band and anchor of catheter to prevent trauma by 11/13/15. 4.) Residents who have a catheter in place will be checked by the Administrator, Director of Nursing or designee to insure that a leg band has been applied to anchor the tubing of the catheter weekly x 4. If compliance is maintained, listings will be pulled on a monthly basis to insure continued compliance is maintained. A report will be provided to the Quality Assurance and Performance Improvement Committee and reviewed on a monthly basis. If indicated, additional training will be provided by the Director of Nursing or designee.	

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F 315	Continued From page 14 Interview with Licensed Practical Nurse (LPN) #2 on 10/08/15 at 1:41 PM revealed she was the nurse who had discovered the skin tear on Resident #12 on 05/25/15. LPN #2 stated that Resident #12's urinary catheter had been leaking and when she pulled Resident #12's foreskin back she noticed an open area on the penis. LPN #2 further stated that all urinary catheters should be anchored either with a leg strap or by being clipped to the bed linens. LPN #2 stated that Resident #12's urinary catheter was not secured at the time she discovered the skin tear to Resident #12's foreskin on 05/25/15. Interview with State Registered Nurse Aide (SRNA) #3 on 10/08/15 at 2:19 PM revealed she had provided catheter care for Resident #12 in the past and had never noticed the catheter to not be anchored. Further interview with SRNA #3 revealed Resident #12 had a leg strap that was used to anchor his/her catheter. Continued interview with SRNA #3 revealed she had noticed the leg strap to be slipped off in the past, but had never observed Resident #12 take the leg strap off. Further interview with SRNA #3 revealed she was not aware of an intervention on the Nurse Aide Care Plan related to Resident #12's catheter being anchored, but that it was facility policy for all catheters to be anchored with a leg strap or clipped to the resident's bed linens. Interview with Registered Nurse (RN) #1 on 10/08/15 at 2:33 PM revealed all catheters were to be anchored by a leg strap or clipped to the sheets. Continued interview with RN #1 revealed Resident #12 had refused to wear a leg strap to anchor his/her catheter in the past. Further interview with RN #1 revealed it was the	F 315		

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F 315	<p>Continued From page 15</p> <p>responsibility of all nursing staff to ensure that urinary catheters were anchored and that it was facility policy for all catheters to be anchored.</p> <p>Interview with the Unit Manager (UM) for Unit Two on 10/08/15 at 2:50 PM revealed Resident #12 had a leg strap to anchor his/her catheter and she was not sure if Resident #12's urinary catheter had been anchored when the skin tear was discovered on 05/25/15. Further interview with the UM revealed the facility policy was that all catheters were to be anchored with a leg strap or clipped to the resident's bed linens and she was not aware of any reason why a catheter would not be anchored. Continued interview with the UM revealed it was the responsibility of all nursing staff to ensure that indwelling urinary catheters were anchored. The UM stated she did not monitor to ensure that indwelling urinary catheters on her unit were anchored and she was not aware of anyone in the facility monitoring to ensure that catheters were anchored.</p> <p>Interview with the facility Director of Nursing (DON) on 10/08/15 at 5:46 PM revealed she had observed Resident #12 to pull on his/her leg strap in the past and had also observed him/her to take the leg strap off in the past. The DON stated that facility policy was that all catheters were to be anchored using either a leg strap or by clipping the catheter tubing to the resident's bed linens. Continued interview with the DON revealed she was unsure if Resident #12's catheter was anchored on 05/25/15 at the time the skin tear was discovered. The DON stated it was the responsibility of all nursing staff to ensure that indwelling urinary catheters were anchored. Continued interview with the DON revealed that she conducted daily walking rounds to ensure</p>	F 315		

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F 315	Continued From page 16	F 315		
F 328 SS=D	that catheters were anchored and was not aware of any issues with catheters not being anchored. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 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. 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 proper treatment and care related to oxygen therapy for one (1) of twenty (20) sampled residents (Resident #3). Resident #3's physician orders included oxygen therapy at two (2) liters per minute (L/min) continuously. However, observations on 10/06/15, 10/07/15, and 10/08/15 revealed Resident #3's oxygen was not in use. The findings include: Review of the facility policy entitled "Oxygen Administration," dated April 2014, revealed general information concerning oxygen safety and precautions during oxygen administration. Further review of the policy revealed, "Staff is to	F 328	F328 1.) On 10/8/15 resident #3's oxygen was reapplied as ordered. A respiratory assessment was completed by a licensed nurse and the physician notified of the assessment findings. Oxygen is currently being administered per physician orders. The care plan has been reviewed by the interdisciplinary team (IDT) and was noted as current and compliant per physician orders related to oxygen administration. The IDT is composed of a Registered Nurse, Activities Director, Social Services Director, Dietary Manager and Administrator. 2.) On 10/9/15, all residents with physician orders for oxygen were assessed for oxygen administration delivery according to physician's orders related to oxygen administration and all were complaint. 3.) By 11/13/15 all licensed nursing staff will be educated by the Director of Nursing or designee on oxygen administration, following physician orders related to oxygen and monitoring the resident receiving oxygen.	11/13/15

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F. 328	<p>Continued From page 17</p> <p>verify that there is a physician's order for the procedure, review the physician's orders or facility protocol for oxygen administration, and review the resident's care plan to assess for any special needs of the resident."</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #3 on 05/08/13 with diagnoses that included Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Recurrent Pneumonia, Dementia, Major Depressive Disorder, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated 08/09/15 revealed the facility assessed Resident #3 to require the use of oxygen. Review of the physician's order dated 08/02/15 revealed Resident #3 had an order for oxygen at 2 L/min via nasal cannula continuously. Review of the Comprehensive Care Plan dated 07/17/14 revealed Resident #3 to have interventions for oxygen at 2 L/min per nasal cannula. Review of the Medication Administration Record (MAR) revealed staff was to check Resident #3's rate of oxygen every shift to assure it was at 2 L/min.</p> <p>Observations on 10/06/15 at 12:05 PM, 12:30 PM, 12:50 PM, 3:05 PM, 4:30 PM, and 5:40 PM, on 10/07/15 at 9:10 AM, 10:10 AM, 10:55 AM, and 12:10 PM, and on 10/08/15 at 9:30 AM revealed Resident #3 to not have oxygen in use.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 10/07/15 at 11:00 AM revealed she thought the order for Resident #3's oxygen was as needed and not continuous and that it was kept in the room in case the resident needed it. She also stated that Resident #3 often takes his/her oxygen off and throws it on the floor. She stated</p>	F 328	<p>4.) On 10/9/15 and ongoing thereafter, licensed nurse will monitor all their assigned residents with orders for oxygen every shift. Physician's orders will be reviewed daily by the Director of Nursing or designee for new or changing physicians' orders related to oxygen. Daily audits of current orders and any order changes will be performed by the Director of Nursing or designee to ensure the orders are accurately reflected on the Medication Administration Record (MAR) and the care plan as well as assess the resident for oxygen administration delivery according to the change. The Director of Nursing will bring the result of the audits to the Quality Assurance and Performance Improvement monthly.</p>		

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F 328	<p>Continued From page 18</p> <p>that she utilized the CNA care plan to find out the care needs of the residents and the nurse responsible for the resident tells the CNAs what the care needs are for the residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/07/15 at 12:15 PM revealed she was responsible for Resident #3's care. She stated that she thought Resident #3's order for oxygen was as needed, not for continuous. She looked at the physician's order on the computer and stated the order was for oxygen at 2 Liters per Minute (L/min) per nasal cannula continuously. Furthermore, she stated that the resident takes off his/her oxygen and "will not keep it on." She stated that the nurse caring for the resident was responsible for making sure that the oxygen was administered as ordered.</p> <p>Interview with the Director of Nursing (DON) on 10/08/15 at 10:10 AM revealed she thought Resident #3's order for oxygen was PRN (as needed). She stated that his/her oxygen saturation has been good for a while now. She stated the resident takes the oxygen off and throws it on the floor and was noncompliant with use. She also stated that it was the nurse's responsibility to make sure the residents receive the proper treatments, including oxygen therapy.</p>	F 328			

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K 000	INITIAL COMMENTS BUILDING: 01 PLAN APPROVAL: 1961, 1982, 1997 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V Unprotected SMOKE COMPARTMENTS: 7 FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic dry sprinkler system GENERATOR: Type II diesel generator A life safety code survey was initiated and concluded on 10/07/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred six (106) beds with a census of ninety-four (94) residents on the day of the survey. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018		

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

TITLE

(X6) DATE



Administrator

10-28-15

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.

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: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422	
(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 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-six (26) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 10/07/15 at 4:05 PM, with the Maintenance Director, revealed a trashcan placed in front of resident room door 123 to prevent the door from closing. Interview with the Maintenance Director at the time of observation revealed no objects were to be placed in front of</p>	K 018	<p>1.) The impediment (trash can) to closing resident room door 123 was immediately removed when observed on facility tour on 10/7/15. The door remains free of impediment to closing.</p> <p>2.) On 10/8/15 Maintenance staff completed an inspection of the door noted above and determined if door was working properly and able to stay open free of obstructions. Maintenance staff completed an inspection of all doors in the facility on 10/8/15.</p> <p>3.) An in-service was completed with all staff by the Maintenance Director and Administrator by 11/13/15. This in-service was aimed at educated all staff on the importance of keeping doors and egress passages free of clutter of impediments to include trash cans holding open doors.</p> <p>4.) Audits of resident doors will be conducted to ensure no impediments are present weekly for 4 weeks, then monthly for 3 months, then quarterly by the Maintenance Director or designee to ensure compliance. All findings will be reported at the monthly Quality Assurance and Performance Improvement Meetings.</p>	11/13/15

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K 018	<p>Continued From page 2</p> <p>resident room doors. The Maintenance Director stated he was not aware of any work orders created to fix the resident room door.</p> <p>The Administrator acknowledged the findings during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the</p>	K 018		

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K 018	Continued From page 3 door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 029 SS=D	19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by:	K 029	1.) The Maintenance Department removed all stored furniture from room 16 and placed the room back in service for resident use on 10/8/15. 2.) All residents have the potential to be affected. On 10/8/15 the Maintenance Department checked all facility doors to assure that self-closing devices were installed on doors according to K029.	11/13/15

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K 029	<p>Continued From page 4</p> <p>Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-three (23) residents, staff, and visitors.</p> <p>The findings included:</p> <p>Observation on 10/07/15 at 3:50 PM, with the Maintenance Director revealed resident room 16 was being used to store furniture and wheelchairs. Further observation revealed the resident room door was not equipped with a self-closer. Interview with the Maintenance Director at the time of observation revealed the resident room had been used to store the items for the last month due to an ongoing construction project. Further interview with the Maintenance Director revealed he was not aware the door needed to be equipped with a self-closer since using the room for storage was only temporary.</p> <p>The Administrator acknowledged the findings during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or</p>	K 029	<p>3.) On 10/8/15 the Administrator educated the Maintenance Department on the importance of self-closing doors under NFPA guidelines. The Maintenance Department will check facility self-closing doors monthly to assure compliance with K 029.</p> <p>4.) The Administrator will review the self-closing door records completed by the Maintenance Department each month. Finding will be reported monthly to the Quality Assurance and Performance Improvement Committee.</p>	

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K 029	<p>Continued From page 5</p> <p>automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms</p> <p>(2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</p> <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p>	K 029		