

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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/30/2013
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based on implementation of the acceptable POC, the facility was deemed to be in substantial compliance, 10/28/13, as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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F 000	INITIAL COMMENTS	F 000	The following actions were completed on 9/12/13 for the patient affected by the practice. The care plan indicated, "Administer IV fluids as ordered." The wording of the care plan refers the reader back to the MD order; however, the statement was removed from the care plan. The oxygen therapy was also removed from the care plan. Care plans were reviewed for accuracy by the Director of Nursing and the MDS licensed nurses beginning 9/13/13 for current patients with review completion by 10/28/13. Licensed nursing education was performed on 10/7/13 by the Director of Nursing regarding the need for care plan accuracy and the systemic changes required to prevent the deficient practice from reoccurring. Any admitted patient has the potential to be affected by the practice of not updating the care plan in a timely manner. The following practices will be initiated in order to ensure the practice does not recur: Registered Nurses will review physician orders at least three times a week in order to update the care plan. The Director of Nursing or RN designee will perform documented random audits weekly on a minimum of two patients with physicians' order changes. These audits will be performed weekly by the Director of Nursing until 100% compliance has been achieved consistently for three months. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Quality Assurance Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted.	F 280 10/28/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the comprehensive care plan was revised for one (1) resident (#3), in the selected sample of fifteen (15) residents. The facility had	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Quint H. Campbell, Administrator TITLE: _____ (X6) DATE: 10/29/13

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 280	<p>Continued From page 1</p> <p>discontinued intravenous (IV) fluids and oxygen therapy for Resident #3; however, did not update the care plan to reflect the resident's current care needs.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 09/13/13 at 11:10 AM, revealed there was no facility policy related to care plan revision.</p> <p>Record review revealed the facility admitted Resident #3 on 08/16/93 with a re-admit date of 01/10/11. Diagnoses included Chronic Airway Obstruction and Stage III Chronic Kidney Disease. Review of the significant change Minimum Data Set (MDS) assessment, dated 08/16/13, revealed the facility assessed the resident as moderately cognitively impaired with a diagnosis of Dehydration.</p> <p>Review of the Comprehensive Care Plan, dated 08/13/13, revealed staff should provide oxygen at two (2) liters per nasal prongs/mask, continuously. Review of the physician's orders, dated 09/04/13, revealed to discontinue the oxygen therapy; however, review of the care plan revealed the care plan was not updated to reflect the order.</p> <p>Review of the Comprehensive Care Plan, dated 08/14/13, revealed to administer the residents IV fluids as ordered. The care plan revealed to monitor the IV site for signs and symptoms of infiltration or infection. Review of the physician's orders, dated 08/23/13, revealed to discontinue the IV; however, the care plan was not updated to reflect the order.</p>	F 280			

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F 280	Continued From page 2 Interview with MDS Coordinator #1 and #2, on 09/12/13 at 2:50 PM, revealed they receive a copy of all nursing orders, and update the comprehensive care plans daily, as needed. They both revealed it was their responsibility to ensure the care plans were revised in a timely manner. Interview with the DON, on 09/13/13 at 11:10 AM, revealed she expected the MDS Coordinators to review all nursing orders and update the care plans accordingly.	F 280	Corrective action: gerisleeves were placed on the patient and individualized staff education was performed. On 9/13/13 the licensed charge nurses were instructed by the Director of Nursing to visually inspect all patients in order to ensure no others were affected. On 10/3/13 all nursing staff were educated by the Director of Nursing that all patients must have the care plan interventions implemented daily and that it is the nursing staff's responsibility to review the care plan daily. Currently, visual inspection is completed daily by all nursing staff for implementation of care plan interventions. The Registered Nurses were educated again on 10/7/13 regarding care plan audits including visual inspection of the patients for implementation of care plan interventions. All patients have the potential to be affected by this practice. Measures put into place to ensure the practice will not recur: The DON or RN designee will perform documented weekly audits on a minimum of two patients comparing the care plan interventions with staff knowledge and intervention implementation through visual patient observation. These audits will be performed weekly by the Director of Nursing until 100% compliance has been achieved consistently for three months. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Quality Assurance Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted.	F 282 10/28/13	
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, record review and staff interview, the facility failed to provide care according to the resident's written plan of care for one (1) residents (#4), in the selected sample of fifteen (15) residents. Observations revealed Resident #4's geri-sleeves and were not own according the care plan. The findings include: A review of the facility policy for Comprehensive Care Plan, undated, revealed it is the policy of the facility to develop a comprehensive care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, and mental and psychosocial needs that	F 282			

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F 282	Continued From page 3 are identified in the comprehensive assessment. 1. Record review revealed the facility admitted Resident #4 on 04/18/11 with diagnosis which included Alzheimer's Disease, personal history of fall, Dementia, Anxiety, Generalized Pain and Depressive Disorder. A review of the Minimum Data Set (MDS) assessment, dated 07/12/13, revealed the facility assessed Resident #4's cognition as moderately impaired. Review of Resident #4's Comprehensive Care Plan, dated 04/16/13, revealed the resident was at risk for skin tears with an intervention for geri-sleeves to bilateral arms. Interviews with MDS Coordinator #1 and #2, on 09/13/13 at 10:10 AM, revealed Resident #4 was care planned to wear geri-sleeves to both arms. Observations on 09/10/13 at 10:10 AM and 3:00 PM, on 09/11/13 at 9:35 AM, 10:30 AM and 3:30 PM, on 09/12/13 at 9:15 AM and 12:15 PM and on 09/13/13 at 9:50 AM revealed the resident was not wearing geri-sleeves. An interview with State Registered Nurse Aide (SRNA) #2, on 09/13/13 at 10:00 AM, revealed she didn't think the resident was care planned for geri-sleeves. The care plan was reviewed on the kiosk by the SRNA and it was determined the resident was care planned for geri-sleeves.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 4</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one (1) resident (#2), in a selected sample of fifteen (15) residents related to the identification/monitoring of wounds.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #2 on 08/10/10 with diagnoses which included Senile Dementia, Swelling, mass in chest, Pneumonia and Pressure Ulcer, upper back.</p> <p>A review of the annual Minimum Data Set (MDS) assessment, dated 08/11/13, revealed the facility assessed Resident #2's cognition as moderately impaired and at risk for skin breakdown.</p> <p>A review of the Comprehensive Care Plan for risk for skin breakdown, dated 06/15/11, revealed an intervention to assess skin weekly and a care plan for "actual" skin breakdown related to a healing stage IV pressure sore to the back.</p>	F 309	<p>Corrective action for the patient affected by this practice included a thorough wound assessment of the calloused area to the right foot with physician notification on 9/12/13. All patients have the potential to be affected by this practice. Systemic changes made to ensure the deficient practice will not recur: A Skin Assessment form has been developed and implemented that must be completed by the licensed nurse performing the weekly skin assessment procedure. The form requires documentation of any non-intact skin as well as any bruises, abrasions, and rashes present at the time of the assessment. If new skin ulcers are identified at the time of the assessment, the licensed nurse will complete the wound assessment documentation required by policy. Licensed nurse education was provided by the Director of Nursing on 10/7/13 related to the new documentation requirements. Monitoring of performance to ensure solutions are sustained: The DON or RN designee will perform weekly audits of the Skin Assessments for completion on 100% of the patients. These audits will be performed weekly by the Director of Nursing until 100% compliance has been achieved consistently for three months. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Quality Assurance Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted.</p>	F 309 10/28/13	

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F 309	<p>Continued From page 5</p> <p>Observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #1 for Resident #2, on 09/11/13 at 3:20 PM, revealed a red with white scabbed area measuring one (1) centimeter (cm) x 1 cm on the outer aspect of the left foot and a red with brown scabbed area measuring 3.0 cm. x 3.5 cm. on the outer aspect of the right foot. Interview with LPN #1 at the time of the observation revealed staff had identified the areas as "bunions" and were monitoring the areas to ensure the areas did not worsen. LPN #1 revealed staff had not measured the areas because the wound care nurse had stated they were bunions and they should monitor.</p> <p>Observation of Resident #2's area on the right outer aspect of the right foot with the Director of Nursing, on 09/12/13 at 3:20 PM, revealed the DON stated that it was a callus on the outer aspect of the right foot with something potentially "brewing" underneath. There was no drainage noted. The DON stated she expected staff to monitor every shift and notify the physician of the area. The DON revealed she expected the physician to be notified on the non-immediate call list. The DON stated she was not sure if staff put her on the list yesterday, but the physician would be notified today (09/12/13). The DON revealed she expected the nurse to document the area on their assessment in the computer.</p> <p>Review of Resident #2's skin assessments and nursing notes prior to 09/11/13 revealed there was no evidence the areas on the outer aspect of both feet were identified prior to this assessment. Further review revealed there was no evidence the areas had been identified during the assessment conducted in the presence of the surveyor on 09/11/13 until 09/12/13 at 3:58 PM.</p>	F 309			

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F 309	Continued From page 6 In addition, there was no evidence the physician was notified of the area. Review of Resident #7's Wound Evaluation Flow Sheets, revealed there was no flow sheet to address the areas identified on the outer aspect of both feet. Review of the physician non-immediate notification list utilized at the time of the survey revealed there was no evidence the LPN had placed Resident #2's name and brief description of the areas on the list. Interview with LPN #1, on 09/12/13 at 3:35 PM, revealed skin assessments findings should be documented in the nursing notes and the assessments are documented under the assessment tab in the medical record. The LPN stated she did not document her assessment findings on 9/11/13 in the nursing notes, behind the assessment tab and failed to place the findings on the physician non-immediate notification list but confirmed that he/she should have.	F 309			
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	The patient chose to eat the cookies even though she understood that she was on a mechanically altered diet and after refusing alternatives of sherbet and yogurt. The corrective action for the patient affected by the practice was that the charge nurse assisted the patient back to her room and administered a scheduled breathing treatment. All patients who have a physician's order for a mechanically altered diet have the potential to be affected by this practice.	F 323 10/28/13	

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F 323	<p>Continued From page 7</p> <p>by:</p> <p>Based on record review and staff interview it was determined the facility failed to ensure each resident receives adequate supervision to prevent accidents for one (1) resident (#7), in the selected sample of fifteen (15) residents. Resident #7 was given a cookie by a facility volunteer and the resident was on a pureed diet.</p> <p>The findings include:</p> <p>Facility policy for Mechanically Altered Diet, undated, revealed that a mechanically altered diet shall be provided for any patient as needed and will be included in the standing physician orders.</p> <p>1. Record review revealed the facility admitted Resident #7 on 02/26/10 with diagnoses which included Morbid Obesity, Unspecified Dysphagia, Diabetes and Esophageal Reflux.</p> <p>Review of Resident #7's Swallow Protocol, dated 06/14/12, revealed the resident was assessed as requiring a dysphagia blenderized diet (Puree).</p> <p>Review of Resident #7's September 2013 physicians orders revealed the resident should receive a pureed diet with consistent carbohydrates and no added salt.</p> <p>Review of the Comprehensive Care Plan, dated 07/07/11, revealed the resident was to receive a puree diet as ordered by the medical doctor (MD).</p> <p>Observation, on 09/10/13 at 11:25 AM, revealed Resident #7 was in the dining room with staff in attendance at a volunteer led activity. The resident got choked after eating a cookie that was reportedly provided to the resident by a volunteer.</p>	F 323	<p>Systemic changes to be put into place are as follows: When a patient requests food that is contrary to a physician-ordered diet, staff or volunteers to whom the request is made is to deny the request and seek assistance from the charge nurse so that risks can be articulated to the patient. In the absence of a physician's order supporting a liberalized diet upon patient request, food given to a patient by any facility representative or volunteer will be in accordance with prescribed diet and patient choice will be denied. Staff were educated on 10/23/13 by the Administrator and the Director of Nursing and Volunteers were educated regarding this systemic change on 10/8/13. Monitoring will be performed by the Activities Director or designee during every activity that serve food choices to ensure that food choices are consistent with prescribed diet. This systemic change will be ongoing, without an end. The Activities Director will report monthly to the internal Quality Assurance team the number of activities where food has been offered and compliance with the systemic change. This Quality Assurance report will be ongoing, with no end.</p>		

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F 323	Continued From page 8 Nursing staff was summoned to the area to assist the resident who was taken back to her room by the nurse. Interview with Resident #7, on 09/10/13 at 11:45 AM, revealed he/she wanted the cookie and it was given to her. The resident stated he/she ate two (2) cookies and was aware he/she was on a pureed diet. An interview with the Dietary Manager, on 09/10/13 at 11:55 AM, revealed Resident #7 was given a cookie by the volunteer. The resident was offered sherbet or yogurt but wanted the cookie instead. The Dietary Manager stated the volunteers were made aware of the residents' dietary restrictions by the staff working in the area.	F 323			
F 371 SS=E	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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was served under sanitary conditions in the dining room.	F 371	The corrective action for this patient, and the routine for each meal for all patients is that tables are thoroughly cleaned with sanitizing solution prior to meal service. The immediate corrective action for patients affected by the practice of food transportation on dirty carts is that dietary staff are cleaning all utility carts with sanitizing solution prior to each meal.	F 371 10/28/13	

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F 371	<p>Continued From page 9</p> <p>Additionally, the facility failed to ensure food was served at the appropriate holding temperature.</p> <p>The findings include:</p> <p>1. Review of the Dietary Department Policies and Procedures, undated, revealed clean cart with sanitize water, detergent and bleach.</p> <p>Observation, on 09/10/13 at 11:56 AM, revealed utility carts were stored in the resident dining area with dirty cups, glasses and plates of food during meal pass. Knats were noted flying around the dirty utility carts. A dirty table with food particles and dried liquid was noted in the resident dining area at a table where a resident was waiting for meal service.</p> <p>Observation on 09/11/13 at 11:53 AM, revealed dirty utility carts stored in the resident dining area with dirty cups, glasses and plates of food during meal pass. Flies and knats flying around dirty utility carts and resident tables. Noted that staff used dirty utility cart during meal pass to transport clean meal trays from the dining area to the resident hall.</p> <p>Interview with the Dietary Manager, on 09/13/13 at 11:00 AM, revealed she expected dietary staff to clean carts prior to meals. She stated she was concerned with cross contamination with dirty food and liquids left on utility carts.</p> <p>2. Review of the Food Temperature policy, undated, revealed food that was at the proper food temperature would be served. Holding temperature for cold food was 41 degrees or below.</p>	F 371	<p>All patients who are served meals from the dietary department have the potential to be affected by this practice.</p> <p>Systemic changes: Prior to each meal pass, dietary staff will have sanitized utility carts available inside the kitchen area for transportation of food trays as needed.</p> <p>Education was provided to the dietary staff by the Dietary Manager on 10/9/13 regarding these systemic changes. Monitoring will be performed by the Dietary Manager who will conduct documented audits three times per week to ensure that sanitized utility carts are available inside the kitchen for food tray transportation, table tops and utility carts in the dining area are properly sanitized prior to meal serve. These audits will be performed three times a week until 100% compliance is achieved for three consecutive months. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Quality Assurance Committee will determine when consistent compliance has been attained and when the frequency of the monthly audits can be adjusted. Regarding food temperatures being out of range: Each food item that exceeded the 41 degree temperature acceptable for cold food was freshly prepared, i.e. the lettuce, tomatoes and onions were sliced and placed in containers on ice and the pimento cheese was freshly made. Immediate corrective action: Dietary staff were instructed by the Dietary Manager on 10/8/13 to place all freshly prepared items in the freezer until a temperature of 41 degrees or below is reached at which time the items may be served or moved to the refrigerator until time for serving.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
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F 371	<p>Continued From page 10</p> <p>Observation of cold food temperatures prior to meal service, on 09/10/13 at 11:45 AM, revealed the following:</p> <p>lettuce- 52 degrees Farenheit (F) tomatoes- 58 degrees F onions- 59 degrees F pimento cheese cup- 59 degrees F pimento cheese sandwich- 59 degrees F</p> <p>Observation, on 09/10/13 at 12:00 PM, revealed resident trays were prepared with lettuce, tomatoes, and onion, and placed on the food cart. Additionally, a pimento cheese cup and two (2) pimento cheese sandwiches were placed on resident trays.</p> <p>Interview with the Cook, on 09/10/13 at 12:00 PM, revealed she was aware cold food items should be served at 40 degrees or below.</p> <p>Interview with the Dietary Manager, on 09/10/13 at 12:10 PM, revealed cold food should be served at 41 degrees or below. If the holding temperature was above 41 degrees, it should be placed in the freezer until at the appropriate temperature.</p> <p>Interview with the Administrator, on 09/13/13 at 9:50 AM, revealed she expected kitchen staff to have an alternate plan if food temperatures were not within the required range. She ultimately expected staff to serve food at the appropriate temperature, per the facility policy.</p>	F 371	<p>Immediate corrective action for the employee who was aware that temperatures exceeded 41 degrees but continued to serve received instruction and education on 9/10/13 by the Dietary Manager that in any instance where cold food temperatures exceeded 41 degrees there must be an alternate food item or items served.</p> <p>All patients who are served meals from the dietary department have the potential to be affected by this practice.</p> <p>Systemic changes: The dietary staff are to place all freshly prepared items in the freezer until a temperature of 41 degrees or below is reached at which time the items may be served or moved to the refrigerator until time for serving. The entire dietary department staff was educated regarding food temperatures of freshly prepared items and serving alternate meals or snacks if improper food temperatures exist on 10/9/13.</p> <p>Monitoring will be performed by the Dietary Manager who will conduct documented audits at least three times per week to ensure that cold food temperatures of freshly prepared items are at least 41 degrees or below. Documented audits will further explain staff actions and alternatives put into place if temperatures are above the acceptable range. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Dietary Manager will report to the Quality Assurance team monthly regarding the status of compliance with sanitation and food temperatures. The Quality Assurance Committee will determine when consistent compliance has been attained and when the frequency of the monthly audits can be adjusted.</p>		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 11</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of</p>	F 441	<p>Corrective action for patients #1 and #3 was generalized staff education regarding appropriate hand hygiene as recommended per standards of practice and was performed on 9/12/13 by the Director of Nursing. All patients receiving incontinence care and wound care have the potential to be affected by the practice. Specific measures to ensure proper hand hygiene is performed included re-educating the licensed nurses and the SRNAs on standards of practice on 9/23/13 by the Director of Nursing. Monitoring staff compliance with hand hygiene will be performed using peer to peer observation as assigned by the DON or RN designee at various times across all shifts. The observations will be conducted covertly during normal routine practices of incontinence and wound care. All of the review results of observed compliance will be reviewed by the DON or RN designee at least weekly until 100% compliance has been achieved consistently for three months. After 100% compliance for three months has been achieved, the audit frequency will be decreased to monthly. The Quality Assurance Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted.</p>	F 441 10/28/13	

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

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F 441	<p>Continued From page 12</p> <p>the facility's policy/procedure, it was determined the facility failed to ensure appropriate hand washing during care for two (2) resident (#1 and #3), in the selected sample of fifteen (15) residents.</p> <p>The findings include:</p> <p>Review of the Universal Precautions policy/procedure, dated 05/22/09, revealed hands were to be washed with soap and water after providing care, if visibly soiled, after removing gloves, and as needed.</p> <p>1. Observation of the provision of care for Resident #3, on 09/12/13 at 10:35 AM, revealed State Registered Nurse Aide (SRNA) #1 provided incontinent care for the resident and did not remove her soiled gloves. Afterwards, the SRNA repositioned the resident in bed, touched the doorknob to the resident's bathroom, and obtained the resident's geri-chair while wearing the soiled gloves. SRNA #1 operated the maxi-lift (touching the lift and lift controller) while transferring the resident from the bed to the geri-chair, wearing the same soiled gloves. During the observation, SRNA #1 touched her own personal clothing while wearing soiled gloves. She then removed her gloves, gathered a soiled linen bag, and left the resident's room without washing her hands. She placed the soiled bag in a room across the hall, then came back to the resident's room and washed her hands.</p> <p>Interview with SRNA #1, on 09/12/13 at 11:00 AM, revealed she should immediately remove her gloves and wash her hands after the provision of incontinent care.</p>	F 441			

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

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F 441	Continued From page 13 Interview with the Director of Nursing (DON), on 09/13/13 at 11:10 AM, revealed she expected staff to use hand sanitizer or wash their hands with soap and water immediately following incontinent care. 2. A review of the facility's Universal Precautions policy and procedure, dated 05/22/09, revealed hands are to be washed with soap and water after providing care, if visibly soiled, and after removing gloves, and as needed. Observation of Resident #1 receiving wound care by Registered Nurse #1, on 09/12/13 at 10:25 AM, revealed RN #1 failed to wash her hands between glove changes during wound care. An interview with RN #1 on 09/12/13 at 10:40 AM, revealed she should have washed her hands between glove changes while providing wound care.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure each bathroom available for resident use was equipped to receive resident calls through a communication system.	F 463	Bathrooms cited in this deficiency are staff and visitor bathrooms located in view of the nurses station, and have been accessible for over 25 years during which time there have been no recommendations for correction. The corrective action taken on 09/13/13 was that all door handles and locks were changed, with locks engaged and keys for entrance placed in a central location so that staff and visitors needing any of the three bathrooms could be given access. Systemic changes to be put into place are: a patient call system will be installed in each of the three noted bathrooms; call system for each bathroom will be connected	F 463 10/28/13	

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

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F 463	Continued From page 14 The findings include: Observation, on 09/10/13 at 10:00 AM, revealed two bathroom's located on 100 hall, and one bathroom beside the nurse's station without an emergency communication system in place. All three bathrooms were unlocked and available for resident use. Interview with the Administrator, on 09/13/13 at 9:50 AM, revealed the two bathrooms located on 100 hall, and the bathroom beside the nurse's station were accessible to residents in the facility. She verified some of the residents used these bathrooms. She was not aware the guest bathrooms were required to have a call system, if accessible to residents.	F 463	with the current communication system located at the nurses' station. To monitor performance, these three bathrooms will be added to the established weekly checklist for ensuring proper operation of each patient call light. Housekeeping and Maintenance staff check each resident call light weekly to ensure proper operation and a log of these checks is kept.		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a Life Safety Code (LSC) survey, conducted 09/11/13, there was one (1) deficiency cited on two previous	F 490	The deficiency under Life Safe Code was regarding required fire drills. Even though fire drills were conducted on all three shifts every calendar quarter as required, the times of the drills were not considered to be random. The corrective action taken is that a calendar has been developed by the Administrator spanning a one year time frame requiring fire drills be performed at pre-specified random times including weekends and holidays on all three shifts. Between the end of the survey on 09/13/13 and 09/28/13, staff participated in four fire drills that included dates of both weekdays and a weekend, with two of the four occurring on the midnight shift and one each on day shift and afternoon shift.	F 490 10/28/13	

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

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F 490	Continued From page 15 annual surveys (10/16/12, 07/06/11) that had not been corrected. (Refer to K0050). The findings include: Interview with the Administrator, on 09/11/13 at 2:30 PM, revealed she had reviewed the fire drills to ensure the drills had been conducted on all shifts at least quarterly. She more concentrated on this aspect of the code and was unaware the drills were being conducted at similar times each quarter. The Administrator signed off on all fire drills as being conducted properly. When she wrote the previous Plan of Correction she thought the definition of a random time meant not the exact time each time.	F 490	Systemic changes to be put into place are as follows: Administrator will develop an ongoing, with no end date, system of documenting deficiencies so that at all times the Administrator is aware of singular deficiencies, i.e. occurring in one year only, and of any deficiencies that have been cited for two consecutive years. If corrective actions for the initial deficiency are not sustained and the practice is cited a second time, the internal Quality Assurance Committee will meet and put into place extensive corrective actions for compliance achievement. Under the direction of the Administrator the internal Quality Assurance team will meet monthly to review compliance issues and achievement. The Administrator will present quarterly reports regarding all deficiencies occurring more than once to the Quality Assurance Committee which includes the Medical Director. These systemic changes will continue with no end date.		

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

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OMB NO. 0938-0391



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NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 21 smoke detectors and 21 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/11/13. HAWES Memorial Nursing and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of Fifty-Seven (57) 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</p>	K 000	<p>Even though fire drills were conducted on all three shifts every calendar quarter as required, the times of the drills were not considered to be random. The corrective action taken is that a calendar has been developed by the Administrator spanning a one year time frame requiring fire drills be conducted at pre-specified random times including weekends and holidays on all three shifts. Between the end of the survey on 09/13/13 and 09/28/13, staff participated in four fire drills that included dates of both weekdays and a weekend, with two of the four occurring on the midnight shift and one each on day shift and afternoon shift. Systemic changes put into place are: An annual calendar has been established by the Administrator that includes pre-determined times and dates for fire drills. The number of scheduled drills exceeds the quarterly mandate and includes 5% on holidays, 46% on weekdays, and 10% during mealtimes over the next year. There are over 40 fire drills scheduled with every month having drills. Staff inservice education was provided on 09/23/13 and included a discussion of fire drills being part of employees' established routine and responsibilities. To monitor performance the following will be done: Prior to the scheduled fire drill, the Maintenance Supervisor or Administrative Assistant will complete the "Fire Drill Adherence to Schedule" form.</p>	9/30/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>George H. Campbell, Administrator</i>	TITLE Administrator	(X6) DATE 10/7/13
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2013
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
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K 000	Continued From page 1 Fire).	K 000	This form will be given to the Administrator for approval of the assigned person of authority who will be conducting the drill and which fire zone will be affected during the drill. Approval will be granted by the Administrator after ensuring the drills are in accordance with the pre-planned schedule and that not only are drills random but that there are also diverse locations of fire compartments affected. The Administrator will follow-up after each fire drill to ensure that the drill did occur and that there is proper documentation of on file.	
K 050 SS=F	A deficiency was cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times. This deficiency was cited on the survey last year on 10/16/2012 and on the previous survey on 07/07/11. The findings include: Fire Drill review, on 09/11/13 at 2:19 PM with the	K 050		

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

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K 050	<p>Continued From page 2</p> <p>Maintenance Supervisor and Environmental Services Supervisor, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely between 1:00 PM and 2:00 PM, and third shift routinely between 10:30 PM and 11:00 PM.</p> <p>Interview, on 09/11/13 at 2:19 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed they more focused their efforts to ensure the drills were being conducted on all shifts at least quarterly. They were still unaware the drill times had to be varied throughout the shift.</p> <p>Interview, on 09/11/13 at 2:30 PM with the Administrator, revealed she has reviewed the fire drills to ensure the drills had been conducted on all shifts at least quarterly. She more concentrated on this aspect of the code and was unaware the drills were being conducted at similar times each quarter. The Administrator signed off on all fire drills as being conducted properly. When she wrote the previous Plan of Correction she thought the definition of a random time meant not the exact time each time.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 10/08/2013
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/30/2013 as alleged	{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.