

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

PRINTED: 08/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
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NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/05/14 and concluded on 08/07/14, with deficiencies cited at the highest Scope and Severity of an "F"	F 000	To the best of my knowledge and belief, as an agent of Carter Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of Federal and State Law. It is the practice of Carter Nursing & Rehabilitation Center to notify a resident's physician when an alteration in treatment occurs. Resident #4's physician was notified on 8/6/14 by the RN unit manager regarding several refusals of medications. No new orders were received from the physician. Resident's care plan was updated to reflect that resident periodically spits out medications. All current resident MAR's will be reviewed by the Health Information Management Coordinator by 9/5/14 to ensure that no other resident has been affected. Residents' physician will be notified by the licensed nursing unit manager in the event that any alteration in treatment is noted upon MAR review.	9/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Denny Joe Brainerd, administrator TITLE
DATE 9/10/14

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified when there was an alteration in treatment for one (1) of twenty-three (23) sampled residents (Resident #4). Interview and record review of the July and August 2014 Medication Administration Record (MAR) revealed medications ordered were not given as ordered or as scheduled related to Resident #4 either refusing to take the medications or spitting the medication out. However, there was no documented evidence the Physician was notified of the alteration in treatment regarding the medications refused or spit out.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Change in Condition" effective date 12/01/10, revealed a change in condition was an indication the current care and treatments were no longer appropriate and the Physician and other members of the health care team were to be consulted to deal with the change and plan treatment alternatives.</p> <p>Record review revealed the facility initially admitted Resident #4 on 08/18/05, and re-admitted the resident on 06/12/14, with diagnoses which included Cerebral Vascular Accident with Left Side Hemiplegia, Non-Alzheimer's Dementia, Coronary Artery Disease, Acute Deep Vein Thrombosis (DVT), a blood clot in a deep vein, and Dysphagia, difficulty swallowing. Review of the Quarterly Minimum</p>	F 157	<p>The Staff Development Coordinator and ADON will provide education to all nurses and CMT's regarding the Center's "Change in Condition and Physician Notification" practice by 9/12/14.</p> <p>The Health Information Management Coordinator will perform 10 MAR audits weekly X 12 weeks. Audit findings will be discussed weekly in the Center's Focus committee meeting and any issues addressed. Audit findings will also be forwarded to the Center's QAPI committee monthly X 3 for review to ensure the solution is sustained.</p>	

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F 157	<p>Continued From page 2</p> <p>Data Set (MDS) Assessment dated 05/20/14, revealed the facility assessed Resident #4 as being severely cognitively impaired.</p> <p>Review of Resident #4's July 2014 Physician Orders revealed orders for: Metoprolol Tartrate (used to treat several cardiovascular diseases) 25 milligrams (mg) twice daily, Pentasa (used to treat inflammation of the colon) 500 mg four times a day, Metformin HCL (Diabetes medication) 500 mg twice daily, Zocor (cholesterol medication) 20 mg tablet once daily, and ProMod Liquid Protein 30 milliliters (ml) twice daily.</p> <p>Review of Resident #4's MAR for June 2014 revealed the medication Metoprolol Tartrate was documented as not administered one (1) time on 06/26/14, the 7:00 PM dose. Doses of the Pentasa medication were documented as not administered on the following dates and times: 06/09/14 at 7:00 AM; 06/14/14 at 11:00 AM; 06/26/14 at 11:00 AM, 3:00 PM, and 7:00 PM; and on 06/27/14 at 3:00 PM. Doses of the medication Metformin HCL were documented as not administered on: 06/09/14 at 9:00 AM; and on 06/26/14 and 06/27/14 at 3:00 PM.</p> <p>However, review of Resident #4's MAR for July and August 2014 revealed a pattern of medications documented as not administered when Certified Medication Technician (CMT) #1 was administering medications. Review of the July 2014 MAR: the medication Metoprolol Tartrate at the 7:00 PM dose were documented as not administered on 07/01/14, 07/02/14, 07/06/14 through 07/09/14, 07/12/14 through 07/15/14, 07/18/14, 07/20/14, 07/21/14, 07/24/14 through 07/27/14, 07/30/14 and 07/31/14, a total</p>	F 157		

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F 157 Continued From page 3
of nineteen (19) doses; the medication Pentasa 3:00 PM and 7:00 PM doses were documented as not administered on 07/01/14, 07/02/14, 07/06/14 through 07/09/14, 07/12/14, 07/13/14, 07/15/14, 07/18/14, 07/20/14, 07/21/14, 07/24/14 through 07/27/14, 07/30/14 and 07/31/14, a total of thirty-six (36) doses; the medication Metformin 3:00 PM doses were documented as not given on 07/01/14, 07/06/14 through 07/09/14, 07/12/14, 07/13/14, 07/15/14, 07/18/14, 07/20/14, 07/21/14, 07/24/14 through 07/27/14, 07/30/14 and 07/31/14, a total of seventeen (17) doses; the Zocor medication 7:00 PM dose was documented as not given on 07/01/14, 07/02/14, 07/06/14 through 07/09/14, 07/12/14 through 07/15/14, 07/18/14, 07/20/14, 07/21/14, 07/24/14 through 07/27/14, 07/30/14 and 07/31/14, a total of nineteen (19) doses; and the ProMod documented as not given at the 4:00 PM dose on 07/02/14, 07/06/14 through 07/09/14, 07/12/14, 07/13/14, 07/15/14, 07/18/14, 07/20/14, 07/21/14, 07/24/14 through 07/27/14, 07/30/14 and 07/31/14, a total of seventeen (17) doses. Further review of the July 2014 MAR revealed CMT #1 had initialed all the above doses of medications as not administered.

Review of the August MAR revealed: the 7:00 PM Metoprolol Tartrate dose was documented as not given on 08/01/14, 08/02/14 and 08/05/14; the Pentasa medication 3:00 PM and 7:00 PM doses documented as not given on 08/01/14, 08/02/14 and 08/05/14; the Metformin medication 3:00 PM dose documented as not given on 08/01/14, 08/02/14 and 08/05/14; the Zocor 7:00 PM dose was documented as not given 08/01/14, 08/02/14 and 08/05/14; and the 4:00 PM dose of ProMod documented as not given 08/02/14 and 08/05/14. Further review of the August 2014 MAR revealed

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F 157	<p>Continued From page 4</p> <p>CMT #1 had initialed all the above medications as not administered.</p> <p>Interview with CMT #1 on 08/07/14 at 10:17 AM, regarding the July and August medication administration not administered, revealed Resident #4 "rarely" took the medication for him despite multiple attempts to administer it. The CMT revealed the resident would not open his/her mouth or would spit out the medications when he gave them. The CMT stated the facility's process was followed when the medications were not administered, as the charge nurse was notified and the "Administration Record" was completed noting why the medication was not administered. CMT #1 further stated it was the charge nurse's responsibility to notify the Physician, and it was important to notify the Physician when medications were not administered. He revealed no one from the facility had addressed the administration problem however.</p> <p>Interview, on 08/07/14 at 3:41 PM, with Licensed Practical Nurse (LPN) #1/Supervisor revealed she worked with CMT #1 and had provided care for Resident #4. The LPN stated she administered Resident #4's Coumadin and had difficulty because he/she would spit it out, but was eventually able to get the resident to take the medication. LPN #1 stated she did not remember CMT #1 informing her Resident #4 was not taking his/her ordered medications. However, she stated such occurrences were supposed to be reported so they could investigated and ensure there was not a problem. In addition, the LPN revealed it was important to notify the Physician to determine if Resident #4's treatment needed to be changed: such as a different medication form, different doses or times, or less medication.</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>Interview, on 08/07/14 at 10:00 AM, with Registered Nurse (RN) #1/Unit Manager (UM) revealed if Resident # 4 was not taking his/her medication the CMT was supposed to inform the nurses who were to investigate and contact the Physician. The RN/UM also revealed it should have been brought to her attention and indicated the the treatment plan might have needed to be changed.</p> <p>Interview, on 08/07/14 at 4:43 PM, with the Director of Nursing (DON) revealed unless a problem was identified they reviewed the resident's MAR prior to care plan conferences, and stated the facility was not auditing the Administration Record. The DON revealed they depended on CMTs to inform the nurses if a resident refused his/her medication and on the nurses to notify the Physician. Per interview, she stated nurses should have been informed if Resident #4 was not taking the medications, and the Physician notified. She stated the concern was the resident had not taken prescribed medication; however Resident #4 had not experienced any negative outcome from the missing the doses of medication.</p> <p>Interview with the Physician on 08/07/14 at 4:31 PM, revealed she was unable to recall if she was notified Resident #4 had not taken medication, but stated she should have been. The Physician revealed if she had been notified she and facility staff could have determined which medications were not taken and investigated ways to get the medication administered. She stated, after being notified by the Surveyor of the medications not given, the missed blood pressure medication was important; however, Resident #4's vital signs had</p>	F 157		

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F 157	Continued From page 6 been checked and were stable.	F 157			
F 176 SS=F	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. 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 assess residents for their ability to safely self administer medications and medications stored appropriately in their rooms if assessed to safely self administer, for four (4) unsampled residents, Unsampled Residents A, B, C and D. Observations revealed the four (4) unsampled residents had both over the counter (OTC) and prescribed medications stored in their rooms at bedside, which included medications, such as, OTC saline nasal spray, OTC lubricating eye drops, prescribed inhalers, prescribed eye medication drops and OTC pink Bismuth stomach medication. The findings include: Review of the facility's, "Self-Administration of Medication" policy, undated, residents who desired to self administer medications were permitted to do so if the facility's interdisciplinary team (IDT) determined the resident was safe to do so, and it was safe for other residents in the	F 176	It is the practice of Carter Nursing & Rehabilitation Center to allow residents to self-administer drugs if deemed safe to do so by the interdisciplinary team. The current policy "Self-Administration of Medication" has been revised and re-named: "Best Practice Guidelines for Self-Administration of Drugs". The nursing administration team (Sheila Rice, RN, AJ Tackett, RN, Sharon Price, RN, Ronda Deboard, RN, Stephanie Dunn, RN) will check all resident rooms in the Center before 8/31/14 for bedside medications to assure that no other residents are affected. Unauthorized medications will be removed and resident's responsible party notified for disposition. The interdisciplinary team will determine whether those residents affected, (unsampled residents A, B, C, & D) are deemed safe to self-administer medications. If so, a physician's order will be obtained regarding self-administration as well as an order to be kept at bedside if deemed appropriate. Care plans will	9/17/14	

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F 176	<p>Continued From page 7</p> <p>facility. This determination was to be made on the IDT's routine and quarterly assessments for residents wishing to self administer, and the resident was to complete a "bedside record" indicating administration of the medication stored at bedside. The "bedside record" was to be reviewed by nursing staff on each shift and by Administration with the information documented on it transferred to the resident's Medication Administration Record (MAR) kept at the nurse's station.</p> <p>Review of the facility's, "Bedside Medication Storage" policy, undated, revealed the facility was to ensure an order for medication to be stored at the resident's bedside was obtained and present in the resident's medical record. Continued review of the Policy revealed a lockable drawer or cabinet was required only if unlocked storage was deemed inappropriate to prevent access of the medication by wandering, confused residents. Review of the Policy revealed all nurses and aides were required to report and take any unauthorized medication found at bedside to the charge nurse who return the medication to the resident's family or responsible party.</p> <p>1. Observation on 08/05/14 at 11:27 AM, revealed Unsampld Resident A's bedside table contained a bottle of OTC liquid dry eye medication, a bottle of saline nasal spray, a prescription Combivent inhaler, prescription Systane lubricating eye drops, and Systane gel eye drops, all lying on top of the bedside table, and easily accessible to other residents. Additional observation on 08/06/14 at 9:35 AM, revealed the all the same aforementioned medications continuing to be stored on the resident's bedside table, and none of the medications were observed to have an</p>	F 176	<p>be updated to reflect the resident's request and ability to self-administer medications in a safe manner. A licensed nurse or certified medication technician will be responsible for the documentation of the self-administered medications after asking the resident if he/she has self-administered the medication. A licensed nurse or certified medication technician will also check the resident's bedside medications to ensure that the open dates are listed on the containers as well as removing any medications that are expired and reordering medications as needed. Notation of these guidelines will be reflected in the residents care plans. Residents will be educated on the proper storage of bedside medications and discouraged from leaving the medications out on bedside tables, etc. Nursing staff will receive education from the Staff Development Coordinator and/or ADON by 9/12/14 regarding the current "Self-Administration of Drugs" best practice guidelines and revisions. The ADON will monitor the performance of the self-administration of medication</p>	

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F 176 Continued From page 8 opened date.

Interview with Unsampled Resident A on 08/06/14 at 9:35 AM revealed he/she had been a nurse for a long time and was aware of how to use the medications.

Review of Unsampled Resident A's clinical record revealed the facility admitted him/her on 04/12/12, with diagnoses which included Chronic Airway Obstruction, Chronic Kidney Disease, Diabetes, Anxiety and Edema. Review of the Physician Orders for August 2014 revealed orders which included: Systane Liquid Gel eye drops, ordered 03/11/14; Systane 0.3-0.4% eye drops, ordered 03/11/14; saline nasal spray, ordered 03/18/13; and Combi Respimate (CombiVent) inhaler ordered 11/25/13. Continued review of the August 2014 Physician orders revealed no documented evidence of a written order indicating Unsampled Resident A could self administer medications; however, the orders indicated these medications could be kept at bedside. Further review of the August 2014 Physicians orders revealed no documented evidence of an order for the OTC dry eye medication observed to be stored at the resident's bedside.

Review of the Medication Self Administration Review sheet dated 06/01/14 revealed Unsampled Resident A was capable of medication self administration; however, there was no documented evidence the resident had been assessed for self administration of the Combivent inhaler, or the Systane eye drops.

Review of Unsampled Resident A's Comprehensive Care Plan (CCP), dated

F 176 practice by completing a weekly audit on all residents that practice self-administration of medication. Immediate correction/re-education will occur if any infractions are noted during the audit. The results will be discussed at the Center's weekly FOCUS committee meeting (Sheila Rice, DON, AJ Tackett, ADON, Infection Control, Sharon Price, RN, Ronda Deboard, RN, Stephanie Dunn, RN, Vicki Stapleton, RN, MDS, Connie Erwin, RN, MDS Judy Holbrook, LPN, MDS, Kim Royse, Social Worker, Bonnie Broughton, Dietary, Lisa Radjunas, Activities, and forwarded to the Center's QAPI committee (Joe Brainard, Administrator, Kari Shields, MD, Brent Lykins, RPH, Sheila Rice, DON, AJ Tackett, ADON, Sharon Price, RN, Staff Development, Ronda Deboard, RN, Stephanie Dunn, RN, Vicki Stapleton, RN, MDS, Connie Erwin, RN, MDS Judy Holbrook, LPN, MDS, Kim Royse, Social Worker, Bonnie Broughton, Dietary, Lisa Radjunas, Activities, Gary Walker, Environmental Services, Jennifer Cotton, Business Office Manager, Matt McCoy, Maintenance) monthly X 3 months for review to ensure that the solution is sustained.

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F 176	<p>Continued From page 9</p> <p>06/02/14, revealed he/she was care planned to properly store and administer medications left at bedside with interventions which included having a Physician's Order in place to self administer medications.</p> <p>Additionally, quarterly medication self administration review sheets were requested for Unsamped Resident A; however, the facility provided no documented evidence of them.</p> <p>2. Observation on 08/05/14 at 11:48 AM, revealed the bedside table contained a bottle of prescription eye drops and two (2) prescription inhalers. Additional observation on 08/05/14 at 1:10 PM, revealed: the eye drops were Pataday prescription eye drops with no opened date; and the inhalers were a Combivent inhaler, with no opened date, and a Dulera inhaler, with no opened date.</p> <p>Interview with Unsamped Resident B on 08/06/14 at 1:10 PM, revealed staff had educated him/her about the medications.</p> <p>Review of Unsamped Resident B clinical record revealed the facility admitted him/her on 02/16/11, with diagnoses which included Morbid Obesity, Atrial Fibrillation, Chronic Airway Obstruction, Depression, Anxiety Congestive Heart Failure. Review of the August 2014 Physician Orders revealed orders which included: Dulera 200 micrograms (mcg)/5 mcg inhaler, order date 08/27/13; Combivent inhalation spray, order date 07/11/13, may keep at bedside; and Pataday 0.2% eye drops, order date 01/09/12. However, continued review of the August 2014 Physician orders revealed no documented evidence of a written order for Unsamped Resident B to self</p>	F 176			

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F 176	<p>Continued From page 10</p> <p>administer medication. Additional review of the Physician Orders revealed the Combivent inhaler had an order indicating it could be kept at bedside; however, there was no documented evidence of orders indicating the Dulera inhaler and the Pataday eye drops could be kept at bedside.</p> <p>Review of the Medication Self Administration Review sheet dated 08/07/14 indicated Unsampld Resident B was capable of medication self administration in all areas of the assessment except reading the prescription label, for which the resident was assessed as needing assistance in reading labels of medications.</p> <p>Review of Unsampld Resident B's CCP, undated, revealed he/she would properly self administer the Combivent inhaler, Ocean Mist nasal spray and Nystatin Powder which were left at bedside. Continued review revealed interventions that included keeping the medication in a locked box for which he/she and nursing staff would retain a key. Review of the CCP revealed Unsampld Resident B was assessed as being able to properly self administer medications, which included the ability to read the medication label. However, the Medication Self Administration Review sheet dated 08/07/14 assessment indicated he/she needed assistance in reading the medication labels.</p> <p>Additionally, the quarterly medication self administration review sheets were requested for Unsampld Resident B; however, the facility provided no documented evidence of them.</p> <p>3. Review of Unsampld Resident C's clinical</p>	F 176		

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F 176	<p>Continued From page 11</p> <p>record revealed the facility admitted him/her on 02/08/10, with diagnoses which included End Stage Renal Disease, Congestive Heart Failure, Anxiety, Depression Chronic Pain and Chronic Airway Obstruction.</p> <p>Observation on 08/07/14 at 1:30 PM, of Unsampld Resident C's bedside table revealed the following medications stored on the table: Proair inhaler (may keep at bedside); TUDOZA Pressair inhaler, with no opened date; OTC Liquears; OTC eyewash, expired 10/2013, not opened; Gentamycin ophthalmic eye drops, expired 09/2013; and Symbicort inhaler, with no opened date.</p> <p>Interview with Unsampld Resident C on 08/07/14 at 1:30 PM, revealed the nursing assistants had helped him/her "clean out the closet a few days ago" and he/she "had not got around to throwing out the expired medication".</p> <p>Review of Unsampld Resident C's Physician Orders for August 2014 revealed orders which included: Tudorza Pressair 400 mcg, ordered 06/23/14; Symbicort 160-4.5 mcg inhaler, ordered 06/23/14; Renvela 800 milligrams (mg), ordered 07/22/14, may keep at bedside and self administer; Liquears eye drops, ordered 04/21/11; and Proair HFA 90 mcg inhaler, ordered 05/27/14, may keep at bedside. Continued review of the Orders also revealed an order for Levaquin 500 mg, an antibiotic, ordered 07/29/14 for Cellulitis in right lower extremity. However, further review of the Physician's Orders revealed no documented evidence of an order for Unsampld Resident C to self administer medication.</p>	F 176		

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F 176	<p>Continued From page 12</p> <p>Review of the Medication Self Administration Review dated 07/22/14, revealed Unsampld Resident C had been assessed as fully capable of medication self administration with the exception he/she needed assist with proper hand washing technique prior to and following self administration of medication which the resident would require as he/she had right lower extremity Cellulitis for which the Levaquin antibiotic was ordered.</p> <p>Additionally, the quarterly medication self administration review sheets were requested for Unsampld Resident C; however, the facility provided no documented evidence of them.</p> <p>Review of Unsampld Resident C's CCP dated 10/23/12, revealed he/she would properly store the Renvela and Proair HFA which was Physician ordered and indicated to be kept at bedside and self-administered. Interventions included the medication would be kept in a locked box in the night stand and the resident would retain the key; it was indicated there was a Physician's Order in place, and that Unsampld resident C could properly self-administer medications. However, the Medication Self Administration Review assessment dated 07/22/14, indicated Unsampld Resident C needed assistance with hand hygiene prior to and after medication self-administration; and the resident had Levaquin ordered for right lower extremity cellulitis.</p> <p>4. Observation on 08/07/14 at 1:40 PM, revealed a nearly empty, approximately ten (10) milliliters (ml) bottle of OTC pink Bismuth upset stomach medication on the bedside table. Interview with Unsampld Resident D, at the time of</p>	F 176		
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F 176	Continued From page 13 observation, revealed the resident stated he/she would have to get more when out with his/her family next time. Review of Unsampld Resident D's clinical record revealed the facility admitted him/her on 02/11/14, with diagnoses which included Congestive Heart Failure, General Osteoarthritis, Atrial Fibrillation and Vitamin B Deficiency. Review of the August 2014 Physician's Orders revealed no documented evidence of orders for any medications which could be left at bedside. Review of the Medication Self-Administration Review dated 08/07/14, revealed Unsampld Resident D had been assessed as fully capable of medication self administration. Additionally, the quarterly medication self administration review sheets were requested for Unsampld Resident D; however, the facility provided no documented evidence of them. Review of Unsampld Resident D's CCP dated 08/07/14, revealed Unsampld Resident D would properly administer medications left at bedside. Interventions indicated there was a Physician's Order in place for the resident to self-administer medications, even though review of the August 2014 Physician's Orders revealed no documented evidence of an order for this. Additionally, the CCP indicated the resident would obtain a locked box to keep at bedside for medications. Interview with Registered Nurse (RN) #2 on 08/07/14 at 4:42 PM, revealed the Medication Self Administration Review sheet was the only teaching tool she used to educate the residents on medication self administration. Continued	F 176		

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F 176	<p>Continued From page 14</p> <p>review revealed she did not have residents sign the sheet to indicate they had received and understood the education.</p> <p>Interview on 08/07/14 at 5:29 PM with the Director of Nursing (DON) and the Administrator revealed that at this time there was not any documentation to verify the residents had received or understood the medication self administration teaching. Continued interview revealed that per the self medication administration review sheet, the resident was responsible for storing the medication and the nurse was responsible for the documentation of administration.</p> <p>Additional interviews on 08/07/14 at 3:25 PM, 3:30 PM, 3:32 PM and 3:42 PM with Licensed Practical Nurse (LPN) #1, LPN #2 LPN #3 and LPN #4, 3:00 PM to 11:00 PM shift supervisors and Charge Nurse, respectively, revealed the process for determining if a resident was able to self administer medications was for the resident to be assessed, an order would be written by the Physician to indicate which medications could be stored at bedside and the medications were to be kept locked in the residents' night stand until ready for use. LPN #3/Supervisor indicated the medications should also not be left in plain sight of other residents and should be in a drawer, but was unaware if the drawer needed to be locked.</p> <p>Interview with Certified Medication Technician (CMT) #2 on 08/07/14 at 6:07 PM, revealed medications which were kept at bedside were reflected on the electronic medication administration record (E-MAR) at the appropriate time for administration. She stated she would go to the resident, remind them to administer the</p>	F 176			

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F 176 Continued From page 15
medication; however did not always watch them take the medication, and would return in a few minutes to see if the resident had administered the medication.

Interview with the DON on 08/07/14 at 6:30 PM revealed the facility did not have an effective system in place to monitor residents to ensure medications were kept locked in a drawer or that the resident was aware of the side effects of the medications. She continued by stating that without an effective monitoring process in place, other residents (wandering/confused) residents could be harmed by the medications left on the residents' bedside tables.

F 323 483.25(h) FREE OF ACCIDENT
SS=E 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 by:
Based on observation, interview, record review and review of the facility's Employee Handbook and documentation, it was determined the facility failed to provide a safe resident environment pertaining to the facility's beauty shop, which contained potentially harmful items, being left unattended with the door open, and wandering residents in the facility.

F 176

It is the practice of Carter Nursing & Rehabilitation Center to provide a resident environment that remains as free of accident hazards as possible; and that each resident receives adequate supervision and assistive devices to prevent accidents. No residents were affected by this practice.

F 323
The Center's Administrator has provided the Beautician education regarding the Center's expectations & handbook as related to "Accident Prevention and Safety" on 8/27/14. The Administrator and/or DON will perform weekly audits X 12 weeks during normal beauty shop hours (Wednesdays) to ensure that the door is shut and locked if the shop is unattended. In the event that an infraction is noted, immediate re-education will occur. Audit results will be forwarded to the Center's QAPI committee monthly X 3 months for review to ensure the solution is sustained.

9/17/14

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F 323	<p>Continued From page 16</p> <p>The findings include:</p> <p>Review of the facility's, "Accident Prevention and Safety" from the Employee Handbook dated March 2012, revealed accident prevention was a continuous effort on the part of all staff.</p> <p>Interview with the Director of Nursing (DON) on 08/06/14 at 1:35 PM, revealed the facility did not have a safety policy for the beauty shop.</p> <p>Observation on 08/06/14 at 1:22 PM, revealed the beauty shop door was open, the light on and no one observed in the shop. Continued observation revealed inside the beauty shop on the wash bowl counter a pair of scissors, metal hair clips, a roll of quarters, metal hair pick, a can of hair spray and a container of Barbicide (a sanitizing solution). Further observation revealed a curling iron plugged in, with an orange light on, indicating it was heated and ready for use, in a slot on the side of the counter.</p> <p>Review of facility documentation revealed the facility identified eleven (11) residents with Code Alert bracelets which indicated they were wandering residents.</p> <p>Review of the Minimum Safety Data Sheet (MSDS) for the Barbicide, dated 12/30/09, revealed to avoid ingestion and eye contact with the product, and it was to be kept out of reach of children. Continued review of the MSDS revealed in ingested the product could cause "probable mucosal damage" and circulatory shock, and immediate medical attention should be sought.</p> <p>Review of the MSDS for the hair spray, updated October 2011, revealed the potential health</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>effects were: for eyes the product might cause mild, transient irritation if it came in contact; for the skin it might cause mild, transient irritation; for inhalation the hair spray might cause mild, transient respiratory irritation; if ingested it might cause mild gastrointestinal irritation with nausea, vomiting and diarrhea. Continued review of the MSDS revealed in the case of accidental ingestion, dilute with fluids (water or milk), do not induce vomiting and seek medical attention if it appeared necessary in the judgment of the "caller".</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 08/06/14 at 1:23 PM, revealed for resident safety the beauty shop should not be left open and unattended.</p> <p>Interview with the Beautician on 08/06/14 at 1:30 PM, revealed she should have closed and locked the beauty shop door when she was returning a resident to his/her room. She further stated it was a resident safety concern to leave the shop open and unattended. Additional interview with the Beautician on 08/07/14 at 7:15 PM, revealed she had been educated on not leaving the shop unlocked and unattended. However, stated she sometimes left the beauty shop door open when she went to get a resident, or take a resident back to their room which took less than five (5) minutes to do either way. Per interview, she stated the beauty shop was open on Wednesday from 9:00 AM to 5:00 PM, and she had been returning a resident to their room on 08/06/14 when the door was observed to be open and unattended. Further interview revealed it was not common practice to leave the door to the beauty shop open and the shop unattended, but she was "human" and sometimes forgot; however,</p>	F 323		

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F 323	Continued From page 18 indicated if left open and unattended wandering residents could enter it. Interview with the DON on 08/06/14 at 1:35 PM, revealed the Beautician had been educated on not leaving the shop open and unattended before as it was a safety issue to do so. The DON indicated the beauty shop should be locked if unattended. Interview with the Administrator on 08/07/14 at 7:12 PM, revealed it was his expectation for the beauty shop door to be closed and locked when not in use, and for staff to be cognizant of that fact. He stated he was unaware of any instance where the beauty shop had been left open and unattended before; however, indicated it was a resident safety concern for it not to be locked. Continued interview revealed the facility had residents who had been identified as elopement risks and wanderers.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441	It is the practice of Carter Nursing & Rehabilitation Center to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. SRNA #4 was immediately made aware of the deficient practice and provided re-education regarding appropriate infection control practices. Resident #4 was provided with a clean Prevalon boot as well as clean bed linens to prevent the potential spread of germs. Infection Control logs have been reviewed by the Administrator and		9/17/14

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F 441 | Continued From page 19
actions related to infections.

(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one (1) of twenty-three (23) sampled residents (Resident #6).

Observation revealed staff failed to remove their gloves and wash their hands after providing Foley catheter/perineal care for Resident #4, prior to providing other care to the resident.

In addition, observation on initial tour on 08/05/14

F 441 | DON and no increase in UTI's is noted among other residents during during 2014.
All resident rooms/bathrooms were checked on 8/27/14 for proper storage and labelling of bedpans by the licensed nursing unit managers. The Staff Development Coordinator and/or the ADON will provide infection control education by 9/17/14 to all nursing staff related to the Center's practice as it pertains to hand hygiene, glove usage, storage/labelling of bedpans and other personal items. The Staff Development Coordinator/ADON will complete foley cath care/perineal care observation audits twice weekly on different shifts and with different nursing staff members. Bedpan storage audits twice weekly X 12 weeks. Audits will occur throughout all 3 shifts. Immediate correction and re-education will be provided for any noted infractions. Results will be forwarded to the Center's QAPI committee monthly X 3 months for review to ensure the solution is sustained.

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F 441	Continued From page 20 and on 08/07/14 revealed a bed pan on the bathroom floor of room #4 and a fracture bed pan in the hand rail in the bathroom of room #8. Both items were uncovered and unlabeled. The findings include: 1. Review of the facility's Infection Control Policy and Procedure Manual policy: "Handwashing/Hand Hygiene, revised 08/2012, revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Continued review revealed handwashing was to be performed before moving from a contaminated body site to a clean body site before and after resident care and after handling contaminated articles. Review of Resident #4's medical record revealed the facility originally admitted Resident #4 on 08/18/05 and re-admitted the resident on 06/12/14 with diagnoses which included Diabetes, Cerebrovascular Accident (CVA) with Left Hemiparesis, Non-Alzheimer's Dementia, and Neurogenic Bladder (problems with the urinary bladder caused by the nervous system). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/20/14, revealed the facility assessed Resident #4 as being severely cognitively impaired. Review of the bowel and bladder assessments revealed the resident was always Incontinent of bowel and had a urinary catheter. Review of the care plan related to Resident #4's indwelling catheter revealed catheter care was to be provided each shift. Observation of Foley catheter and perineal care to Resident #4 by State Registered Nurse Assistant (SRNA) #4, on 08/06/14 at 11:06 AM,	F 441		
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**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185253	FACILITY NAME CARTER NURSING & REHAB	SURVEY DATE * K4 08/06/14
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K6 DATE OF PLAN APPROVAL 1985	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS 1 NUMBER OF THIS BUILDING 1	A BUILDING B WING C FLOOR D APARTMENT UNIT a
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LSC FORM INDICATOR

Health Care Form		
	2786 2000	EXISTING
	2786R 2000	NEW
ASC Form		
	2786U 2000	EXISTING
	2786U 2000	NEW
ICF/MR Form		
	2786V, W, X	2000 EXISTIG
	2786V, W, X	2000 NEW

*K7 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
 2 SLOW
 3 IMPRACTICAL

LARGE

K8: 4 PROMPT
 5 SLOW
 6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
 8 SLOW
 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29 K56:

ENTER E – SCORE HERE)

K5: e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON (Check all that apply)

A1. (COMP. WITH ALL PROVISIONS) A2. (ACCEPTABLE POC) A3. (WAIVERS) A4. (FSSES) A5. (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B.

K0180

A. FULLY SPRINKLERED (All required areas are sprinklered) B. PARTIALLY SPRINKLERED (Not all required areas are sprinklered) C. NONE (No sprinkler system)

* MANDATORY

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

PRINTED: 08/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2014
NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143		
(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 CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1985 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One story Type III Smoke Compartment: Five (5) smoke compartments Fire Alarm: Complete fire alarm system. Panel upgraded in 2006. Sprinkler System: Complete automatic (dry/wet) sprinkler system. System installed in 1985. Generator: Type II A Standard Life Safety Code Survey was conducted on 08/06/14. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			

RECEIVED
AUG 29 2014
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Denny J. Brannard TITLE Administrator (X6) DATE 8/28/14

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.