

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702	
(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 A Standard Recertification Survey was initiated on 07/23/13 and concluded on 07/25/13 with deficiencies cited at the highest scope and severity of an "F".	F 000	Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; 2y Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F272 1. Residents # 3, 7, and 8 have been reassessed by a licensed nurse as to the types of medications they had ordered in coordination with any behaviors they were currently exhibiting. 2. All other residents receiving psychotropic medications will be assessed in accordance with their MDS schedule by the Behavior Committee's interdisciplinary team. This assessment will include the medication, dose, behaviors exhibited by the resident. The results of this assessment will be reflected on the residents CAA. 3. The MDS Coordinators and Social Services Director were re-inserviced by the Staff Development Director	

RECEIVED
AUG 16 2013

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

Bill Collins

TITLE

Administrator

(X6) DATE

08/16/2013

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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Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to adequately assess three (3) of twenty-four (24) sampled residents (Residents #3, #7 and #8) for the use of psychotropic medications and the behaviors leading to the use of these medications. Residents #3, #7 and #8 were identified as receiving antidepressant and anti-anxiety medications.

The findings include:

Review of the facility's policy, "Behavior Management Committee", dated 02/13, revealed residents on psychoactive medications or who have behavior issues will be reviewed by the committee on a quarterly basis.

1. Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Obesity, Cellulitis, Hypothyroidism, Diabetes and Depression. The facility completed an annual Minimum Data Set (MDS) Assessment on 01/06/13 which revealed the resident was cognitively intact. The MDS indicated the resident required extensive assistance with daily care, required a suprapubic catheter, and total assistance with bathing. The resident reported near constant pain, and feeling down and

F 272 F272 (Continued)

on the accurate way to complete a CAA on 08/14/13.

This training reflected directions given in the RAI manual on the completion of a CAA.

The Staff Development Coordinator will audit 50% of the CAA's completed weekly for 4 weeks, then 25% weekly for 4 weeks, then as recommended by the Quality Assurance Committee. The Staff Development Coordinator will provide reeducation as indicated by the audits.

These Audits will be presented to and reviewed with the Administrator weekly.

4. The Administrator will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.

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depressed. The Care Area Assessments (CAAs) revealed the resident received an antidepressant; however, there was no documentation found regarding the resident's depression or any symptoms/behaviors the resident may have exhibited, along with information regarding the effect of pain on the resident's behaviors or the frequency of the behaviors and the efficiency of the antidepressant. In addition there was no documentation located to reflect the resident's feelings regarding the effectiveness of the treatment plan.

Interview with Resident #3, on 07/24/13 at 11:15 AM, revealed she sometimes had issues with staff and got very irritated with them.

2. Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Chronic Respiratory Failure, Anxiety and Hypertension. The facility completed an admission MDS Assessment on 02/21/13 which revealed the resident was cognitively intact, and required extensive assistance with daily living. The resident reported a poor appetite and tired easily. The resident had a tracheotomy and was post status ventilator dependent. The resident received two (2) antidepressants and one (1) anti-anxiety medication. Review of the CAAs, revealed the resident had anxiety; however, no documentation was located regarding the symptoms the resident exhibited in regards to anxiety and/or depression or the effectiveness of the medications to date.

Resident #7 was not interviewed secondary to being too tired to talk.

3. Review of the clinical record for Resident #8,

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revealed the facility admitted the resident with diagnoses of Anxiety, Depression, Diabetes, and Hypertension. The facility completed an admission MDS Assessment on 03/28/13 which revealed the resident was cognitively intact and required extensive assistance with daily living. The resident was incontinent and had frequent pain. The resident received antidepressant and anti-anxiety medications. Review of the CAAs revealed no documentation was located to determine the behaviors/symptoms the resident was having for which the medications were received or the effectiveness of the medications to date.

Interview with Resident #8, on 07/24/13 at 1:30 PM, revealed the resident had no concerns and everything was fine.

Interview with the MDS Coordinator, on 07/25/13 at 10:15 AM, revealed the CAAs did not include the specific behaviors for which residents received psychoactive medications; however, the behaviors probably should be on the CAA as part of the comprehensive assessment. She stated the purpose of the CAA was to identify the complicating factors and risks for the resident in the particular care area. She stated the CAAs did not include the information regarding the residents' symptoms/behaviors to be monitored or the effectiveness of the medications to date.

Interview with the Director of Nursing, on 07/25/13 at 2:06 PM, revealed the CAAs should reflect the complicating factors and risks for each resident triggering in the care areas. She stated the CAAs did not include the residents' behaviors/symptoms for psychoactive medications for Residents #3, #7 and #8.

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F 279 483.20(d), 483.20(k)(1) DEVELOP
SS=D COMPREHENSIVE CARE PLANS

F 279 F279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of facility policy, it was determined the facility failed to develop comprehensive care plans for three (3) of nineteen (19) sampled resident (Residents #3, #7, #8). Residents #3, #7 and #8 all recieved psychoactive medications for anxiety or depressing but did not have a care plan to address behaviors.

The findings include:

Review of the facility's policy, "Care Plans", undated, revealed the resident's care plan

1. Resident # 3 – Her Behavior care plan and the C.N.A. Care plan has been reviewed and revised by a Licensed Nurse on 08/14/13 to include how the resident expresses her anger and individual interventions to guide the staff in protecting other residents during an outburst of anger.

Resident # 7 - His Behavior care plan and the C.N.A. Care plan has been reviewed and revised by a Licensed Nurse on 08/14/13 to include how the resident expresses his nervousness or "nerves" and individual interventions to guide the staff in identifying and relieving these symptoms.

Resident # 8 - Her Behavior care plan and the C.N.A. Care plan has been reviewed and revised by a Licensed Nurse on 08/14/13 to include how the resident expresses her anxiety or depression and individual interventions to guide the staff in identifying and relieving these symptoms.

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provided guidance to all staff caring for residents and communicated changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provided individualization and coordination of resident care.

1. Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Diabetes, Depression, and Hypothyroidism. The facility completed an annual Minimum Data Set (MDS) Assessment, date 01/06/13, which revealed the resident was cognitively intact, required extensive assistance with daily living tasks, had daily pain and complained of feeling down and tired. Further review of the MDS revealed the resident received antidepressants and anti-anxiety medications. The Care Area Assessments (CAA) for psychotropic medications lacked information regarding behaviors/symptoms for these medications.

Review of the current comprehensive care plan for Resident #3, revealed the resident exhibited verbal aggression towards staff and other residents, threatened staff, was verbally abusive and frequently complained of missing personal items. There was no documentation of interventions to guide staff in protecting other residents from the resident's verbal aggression located on the care plan.

Interview with Certified Nurse Aide (CNA) #4, on 07/24/13 at 4:00 PM, revealed Resident #3 was verbally aggressive to staff and other residents at times. She stated the resident was easily irritated and would say mean things to other residents. She revealed the resident became angry easily.

F 279 F279 (Continued)

2. All residents with psychotropic's will have their Behavior care plans and C.N.A. care plans reviewed and adjusted as indicated by a licensed nurse by 08/16/13.

These adjustments will reflect each resident's symptoms and individual interventions.

3. The Care Plan Policy was reviewed by the Director of Nursing and the Administrator on 08/14/13. The Staff Development Coordinator educated Members of the Interdisciplinary team.

(Unit Managers, DON, Social Services, Activities and Therapy) and Nursing staff of the need for Behavior Care plans to include how a resident expresses their behavior and individual intervention to alleviate their behavior beginning on 08/14/13 and completing on 08/16/13.

Unit Managers will Audit each residents care plan in accordance with their MDS schedule for the

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She stated the nursing staff were aware of the resident's behaviors. She stated the care plan did not advise staff how to handle the resident when these behavior occurred.

Interview with the MDS Coordinator, on 07/25/13 at 10:15 AM, revealed she could not located any interventions put in place to protect other residents from Resident #3 or to handle the resident's anger if behaviors occurred. She stated the care plan should have included interventions for these behaviors.

2. Review of the clinical record for Resident #7, revealed the resident was admitted to the facility with diagnoses of Chronic Respiratory Failure and Hypertension. The facility completed an admission MDS Assessment on 02/21/13 which indicated the resident was cognitively intact, had a tracheotomy, required extensive assistance for all daily living task, and was easily fatigued even trying to speak. Further review of the MDS revealed the resident received antidepressants and antianxiety medication.

Review of the current comprehensive care plan for Resident #7, revealed the resident received antidepressants and antianxiety medications. Care plan interventions included: observe for signs/symptoms of drug related issues, report negative outcomes to physician and administer medications as ordered; however, there were no behaviors/symptoms identified and no interventions regarding behaviors/symptoms were located on the care plan.

Interview with CNA #2, on 07/24/13 at 2:45 PM, revealed Resident #7 complained of nerves at times. She stated she would pass this

F 279 F279 (Continued)

inclusion of behaviors and individual intervention weekly for three months, then as recommended by the Quality Assurance committee. These audits will be reviewed with the Director of Nursing who will provide education on an as needed basis.

4. The Director of Nursing will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.

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information along to the nurse.

F 279

Interview with Registered Nurse (RN) #2, on 07/25/13 at 10:00 AM, revealed Resident #7 complained of nervousness. She stated she was not sure what specifically nerves meant; however, she did medicate the resident with an antianxiety medication for the complaint. She stated the care plan did not have behaviors/symptoms noted or interventions to resolve the resident's concerns. She stated the interventions should have been care planned for staff guidelines.

3. Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Anxiety, Depression, Diabetes, and Hypertension. The facility completed an admission MDS Assessment on the resident on 03/28/13 which revealed the resident was cognitively intact and required extensive assistance with daily living. Further review of the record revealed the resident received antidepressant and antianxiety medications.

Review of the current comprehensive care plan for Resident #8, revealed the resident received antidepressant and antianxiety medications. No documentation was located to determine specific behaviors/symptoms the resident experienced.

Interview with RN #2, on 07/25/13 at 10:00 AM, revealed the resident did receive antidepressant and antianxiety medications; however, she was not able to locate information on the care plan regarding any specific behaviors/symptoms exhibited by the resident. She stated the resident had depression and anxiety.

Interview with the MDS Coordinator, on 07/25/13

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at 10:15 AM, revealed specific behaviors/symptoms and interventions should be on the care plan to ensure staff provide the appropriate care.

F 279

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

F 281 F281

The services provided or arranged by the facility must meet professional standards of quality.

1. Resident # 2 was assessed by the dietician on 07/24/13 to determine to proper amount of feeding. His feeding was decreased to 55 cc per hour by the physician on 07/24/13.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to ensure Physician's orders were implemented for care and treatment for gastrostomy nutrition for one (1) of nineteen (19) sampled residents (Resident #2). The facility failed to ensure the Physician's orders for the rate of the enteral nutrition were followed.

2. All residents had their physician orders verified by a licensed nurse as accurate on the medication administration records and the treatment administration records by 08/01/2013.

The findings include:

Record review revealed Resident #2 was admitted by the facility on 09/10/12 with diagnoses which included Anemia, Coronary Artery Disease, Diabetes, Alzheimer's, Organic Brain syndrome, and Gastrostomy Tube.

3. The Director of Nursing approved of the Chart check Policy on 08/12/2013.

Review of the Minimum Data Set (MDS) Assessment, dated 04/26/13, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating cognitive impairment. Further review of the MDS revealed the resident

The Staff Development Coordinator Inserviced the nursing staff on the Chart Check Policy beginning on 08/14/13 and completing on 08/16/13.

Nursing staff will check each residents chart nightly to ensure any order written by the physician

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received nutrition via Gastrostomy tube.

Review of the Physician's orders for Resident #2, revealed an order dated 07/17/13, to increase the enteral nutrition rate to sixty (60) milliliters (ml) per hour.

Observations, on 07/23/13 at 11:58 AM and 5:05 PM; and 07/24/13 at 8:47 AM and 1:27 PM, revealed Resident #2's enteral nutrition was infusing at fifty-five (55) ml per hour.

Interview with the Dietitian, on 07/24/13 at 1:58 PM, revealed she had written a recommendation for the nutrition to be increased from fifty-five (55) to sixty (60) ml per hour. Further interview revealed the rate increase was a difference of one hundred and sixty-five (165) calories per day.

Interview with Registered Nurse (RN) #3, on 07/24/13 at 1:46 PM, revealed she was the primary nurse responsible for Resident #2's care. Further interview revealed, she did not transcribe the information from the Physician's order to the Medication Administration Record (MAR) when the Physician increased the rate. RN #3 stated she just missed the order.

Interview with Unit Manager #3, on 07/24/13 at 1:45 PM, revealed the nutritional rate should have been at the sixty (60) ml per hour per the dietary recommendations and Physician's orders. Further interview revealed the primary nurse was responsible for transcribing the Physician's orders from the order to the Medication Administration Record. Additionally, it was her expectation that staff would follow the Physician's orders for the rate of the enteral nutrition.

F 281 F281 (Continued)

has been transcribed correctly.

The Unit Managers will Audit the Chart Check signatures weekly for 4 weeks, then bi weekly for 4 weeks, then monthly. These audits will be reviewed with the Director of Nursing who will provide education on an as needed basis.

4. The Director of Nursing will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.

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Interview with the Director of Nursing, on 07/24/13 at 2:15 PM, revealed the nutrition rate should have been at sixty (60) ml per hour. Further interview revealed her expectations were that staff would follow the Physician's orders.

F 281

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

F323

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.

1. Resident #9 – Her room was searched by two facility staff on 07/26/13 for hazardous items. The Miracle Grow has been removed and will be stored in a secured area.

2. All residents' rooms were searched for hazardous items by members of the interdisciplinary team on 07/29/13. Resident's rooms are now free from hazards.

3. A copy of the General Policy for Resident's and Responsible Parties which includes hazards of medicated products, appliances, knives scissors and other potentially hazardous materials has made available to residents and responsible parties by the Administrator on 08/01/13.

All staff was educated on 08/14/13 by the Staff Development

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. The facility failed identify a hazardous liquid in Resident #9's room to be hazardous to the facility residents. Miracle Gro was observed to be in Resident #9's room during the survey.

The findings include:

Observations conducted on 07/23/13 at approximately 11:00 AM, during the initial survey tour and the subsequent days of 07/24/13 and 07/25/13, a bottle of Miracle Gro was observed on a table in Resident #9's room next to a green house plant.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702	
(X4) IO 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 323	Continued From page 11 Record review of the Material Safety Data Sheet for Miracle Gro Liquid All Purpose Plant Food revealed it was a hazardous substance and if not used according to the manufacturer's recommendations, with the proper, personal/protective equipment, the liquid may cause harm to an individual's eyes, skin, mouth, throat, esophagus, stomach, and upper respiratory tract. An interview conducted, on 07/25/13 at 1:30 PM, with Unit Manager #3 revealed that she was not aware of a bottle of Miracle Gro being present in Resident #9's room. A interview with the Director of Nursing, 07/25/13 at 2:05 PM, revealed that it was her expectation that all of the residents' rooms would be clear of all hazardous materials.			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterosotomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
F 323	F323 (Continued) Coordinator or their respective Department head to be observant for potentially hazardous items, to remove items if found and deliver them to the resident's charge nurse. These items will then go to the Director of Nursing for resolution. Members of the Interdisciplinary team will audit residents' rooms one time weekly for 4 weeks, then 1 time bi-weekly for 8 weeks, then monthly for three months, then as recommended by the Quality Assurance Committee.			
F 328	These Audits will be reviewed with the Administrator. 4. The Administrator will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.			08/16/13

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F 328 Continued From page 12

F 328 F328

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure residents received necessary care and treatment for gastrostomy nutrition for one (1) of nineteen (19) sampled residents (Resident #2). The facility failed to ensure the Physician's orders for the rate of the enteral nutrition were followed.

The findings include:

Record review revealed Resident #2 was admitted by the facility on 09/10/12 with diagnoses which included Anemia, Coronary Artery Disease, Diabetes, Alzheimer's, Organic Brain syndrome, and Gastrostomy Tube.

Review of the Minimum Data Set (MDS) Assessment, dated 04/26/13, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating cognitive impairment. Further review of the MDS revealed the resident received nutrition via Gastrostomy tube.

Review of the Physician's orders for Resident #2, revealed an order dated 07/17/13, to increase the enteral nutrition rate to sixty (60) milliliters (ml) per hour.

Observations, on 07/23/13 at 11:58 AM and 5:05 PM, and 07/24/13 at 8:47 AM and 1:27 PM, revealed Resident #2's enteral nutrition was infusing at fifty-five (55) ml per hour.

Interview with the Dietitian, on 07/24/13 at 1:58

1. Resident # 2 was assessed by the dietician on 07/24/13 to determine to proper amount of feeding. His feeding was decreased to 55 cc per hour by the physician on 07/24/13.

2. All residents had their physician orders verified by a licensed nurse as accurate on the medication administration records and the treatment administration records by 08/01/2013.

3. The Director of Nursing approved of the Chart check Policy on 08/12/2013.

The Staff Development Coordinator inserviced the nursing staff on the Chart Check Policy beginning on 08/14/13 and completing on 08/16/13.

Nursing staff will check each residents chart nightly to ensure any order written by the physician has been transcribed correctly.

The Unit Managers will Audit the Chart Check signatures weekly for 4

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F 328	Continued From page 13 PM, revealed she had written a recommendation for the nutrition to be increased from fifty-five (55) to sixty (60) ml per hour. Further interview revealed the rate increase was a difference of one hundred and sixty-five (165) calories per day. Interview with Registered Nurse (RN) #3, on 07/24/13 at 1:46 PM, revealed she was the primary nurse responsible for Resident #2's care. Further interview revealed, she did not transcribe the information from the Physician's order to the Medication Administration Record (MAR) when the Physician increased the rate. RN #3 stated she just missed the order. Interview with Unit Manager #3, on 07/24/13 at 1:45 PM, revealed the nutritional rate should have been at the sixty (60) ml per hour per the dietary recommendations and Physician's orders. Further interview revealed the primary nurse was responsible for transcribing the Physician's orders from the order to the Medication Administration Record. Additionally, it was her expectation that staff would follow the Physician's orders for the rate of the enteral nutrition. Interview with the Director of Nursing, on 07/24/13 at 2:15 PM, revealed the nutrition rate should have been at sixty (60) ml per hour. Further interview revealed her expectations were that staff would follow the Physician's orders.				
F 328	F328 (Continued)		weeks, then bi weekly for 4 weeks, then monthly. These audits will be reviewed with the Director of Nursing who will provide education on an as needed basis. 4. The Director of Nursing will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.	08/16/13	
F 371	483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and				
F 371	F371		1. No individual residents have been identified. 2. All residents have the ability to be		

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			(X5) COMPLETION DATE

F 371 Continued From page 14

(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the Kentucky food Code and review of facility's policy, it was determined the facility failed to store, prepare and serve food under sanitary conditions. The facility failed to ensure the ice machine, plate warmer, cookie sheet pans, dietary cart, fans, and food storage bins were clean. The facility failed to ensure staff washed the exposed portions of their arms prior to handling food. The facility allowed dirty paper signs taped on numerous surfaces throughout the kitchen. The facility failed to store plate covers bowl side down or covered. The facility failed to adequately clean surfaces heavily encrusted with tape residue. The facility failed to ensure the trash cans and lids were clean on the outside.

The findings include:

Review of the facility's policy for Sanitation, undated, revealed dishes and plates were stored with the top plate turned over to protect particles from getting on the top plate.

Review of the facility policy for Sanitation, undated, revealed the facility had cleaning schedules to maintain equipment and work surfaces in a sanitary manner. Formal sanitation inspections of the dietary department occurred on a frequent basis. Informal sanitation inspections

F 371 F 371 (Continued)

affected by the observed practice.

3. The kitchen was deep cleaned on 07/29/13 by facility staff that included; dry storage bins, ice machine, trash barrels and lids, large fan, and the plate warmer. Paper signs and excess tape has been removed. New cookie sheet pans were purchased to replace the old ones.

Dietary staff were educated by the Administrator on 08/13/13. This education included; washing hands and arms prior to working in the kitchen and prior to serving food, removing all jewelry prior to work with the exception of their wedding rings, not allowing clean dishes to touch their aprons during transport and to follow the cleaning schedule posted.

The dietary Manager was educated by the Administrator on 07/30/13. On the expectation and need follow through with staff to ensure the cleaning schedule is being followed.

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F 371 Continued From page 15

occurred daily. Cleaning schedules were established to assign specific tasks to scheduled employees on a daily basis. Employees were provided training on correct procedures, cleaning agents and frequency of cleaning.

Review of the Kentucky Food Code 2-301.11, Clean Conditions, revealed food employees shall keep their hands and exposed portions of their arms clean. Review of the Kentucky Food Code 2-301.11 Prohibition, revealed except for a plain ring, such as a wedding ring, employees preparing food may not wear jewelry.

Observation of the kitchen, on 07/23/13 at 9:15 AM, revealed flour, sugar and beans were stored in rolling storage bins with dried substances on the outside and on the lids. Soiled and torn paper signs were observed taped to each of the three bins. Inside the ice machine, a red substance was observed around the rim of the door. Trash barrels and lids were observed to be heavily soiled with drips and smears of dried substances. Large metal cookie sheets stored on shelves were heavily encrusted with a build-up of a black substance. Soiled paper signs were taped all around the surfaces of the kitchen and the freezers and refrigerators doors were covered on the outside with tape residue. A large fan mounted in the corner and running had a cord stained black from the middle down to the tip. Dietary employees were noted to be wearing several rubber bracelets on one or both arms. The plate warmer used during the meal service was heavily soiled with a greasy black build-up around the hinges and the edges next to the opening for the plates.

F 371 F371 (Continued)

The Administrator will audit the kitchen for cleanliness and staff absence of jewelry one time weekly for 8 weeks, bi-weekly for 4 weeks, monthly for 3 months, then as recommended by the Quality Assurance Committee.

4. The Administrator will present these findings to the Quality Assurance Committee monthly to ensure accuracy and completeness of the process.

08/16/13

Observation of the kitchen, on 07/23/13 at 11:45

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F 371	Continued From page 16 AM, revealed Dietary Aides (DA) #2 and #3 preparing to serve lunch. Both DA's were noted to wash their hands up to the wrist where the bracelets were. The bracelets were noted to then fall back down the hand to contaminate the freshly washed hands. In addition, the bracelets were noted to touch glassware and serving utensils. : Observation of the kitchen, on 07/23/13 at 12:10 PM, revealed DA #2 was carrying two (2) stacks of clean bowls to the steam table using the chest area of her uniform to balance the bowls. Interview with DA #2, on 07/23/13 at 12:50 PM, revealed she was not aware that her jewelry contaminated her hands after she washed them. She stated the jewelry could have germs that could make residents ill. In addition, she knew the clean bowls should not have been held against her uniform while she transported them for the same reason. She stated she had received training on infection control. : Interview with DA #3, on 07/23/13 at 1:05 PM, revealed there was a cleaning schedule in the kitchen and everyone was supposed to complete their assigned tasks. She stated the kitchen should be clean to prevent residents from becoming sick from germs. She stated she had received training on infection control. Interview with the Food Service Manager, on 07/23/13 at 1:10 PM, revealed there was a cleaning schedule that she supervised; however, the kitchen was not clean today. She stated the kitchen was not clean because the staff must not have cleaned over the weekend. She stated that staff received training on cleaning. She stated	F 371			

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F 371 Continued From page 17
she was not aware that there were so many soiled paper signs and that they would be removed and the kitchen would be cleaned. She stated training would be provided on hand washing and jewelry. She indicated the kitchen had to be clean to prevent residents from becoming sick from bacteria.

Interview with the Administrator, on 07/25/13 at 2:15 PM, revealed his expectation was that the kitchen would be clean and there would be no foodborne illness.

F 371

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K 000 INITIAL COMMENTS K 000

CFR: 42 CFR 483.70(a)
 BUILDING: 01
 PLAN APPROVAL: 1989
 SURVEY UNDER: 2000 Existing
 FACILITY TYPE: SNF/NF
 TYPE OF STRUCTURE: 3-story, Type 11 (222)
 SMOKE COMPARTMENTS: 7
 FIRE ALARM: Complete automatic fire alarm system
 SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system
 GENERATOR: Type II diesel generator
 A life safety code survey was initiated and concluded on 07/23/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.
 No deficiencies were identified during this survey.

*Acceptable
POC
8/16/13*

RECEIVED
AUG 16 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Collins</i>	TITLE Administrator	(X6) DATE 08/16/2013
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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.