STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review it was determined the facility failed to treat one (1) of thirty-nine (39) sampled residents (Resident #28) with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life. Observation on 03/09/2020 revealed State Registered Nurse Aide (SRNA) #5 standing over Resident #28 during the lunch meal feeding him/her lunch in the resident's room. The findings include: Interview with the Director of Nursing (DON) on 03/11/2020 at 11:00 AM revealed the facility did not have a policy in regard to staff feeding residents. Review of the medical record for Resident #28 revealed the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, Section C, Cognitive Patterns, dated 01/12/2020, revealed the facility assessed the resident to be severely cognitively impaired and therefore a Brief Interview for Mental Status (BIMS) score could not be obtained. Further review of the MDS, Section G, Functional Status, revealed the resident required extensive assistance of one (1) person for eating. Review of the Comprehensive Plan of Care dated 07/05/2017 for Resident #28 revealed a focus area of Activities of Daily Living with an intervention that the resident was to be fed per staff. Observation of Resident #28 on 03/09/2020 at 1:03 PM revealed the resident lying in bed with the head of bed raised and SRNA #5 standing over the resident at bedside feeding the resident. Further observation revealed a chair in the room next to the resident's bed. Interview with SRNA #5 on 03/11/2020 at 5:01 PM revealed she should not have stood and fed the resident. The SRNA further revealed she was nervous with the surveyor in the room. The SRNA revealed she had been trained during orientation to not stand and feed residents. Interview with the DON on 03/11/2020 at 4:34 PM revealed the SRNA should not have been standing and feeding. The DON further revealed staff are educated during orientation on feeding residents. The DON also revealed she monitors residents being fed properly by making rounds and spot-checking and had not identified any concerns with residents being fed inappropriately.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review it was determined the facility failed to complete an accurate assessment for one (1) of thirty-nine (39) sampled residents. Resident #53 had a urinary catheter; however, the facility failed to include the presence of the urinary catheter on the resident's Admission Minimum Data Set (MDS). The findings include: Interview on 03/11/2020 at 12:43 PM with the Director of Nursing (DON) revealed the facility did not have a policy related to the accuracy of the MDS but used the Resident Assessment Instrument (RAI) manual. The RAI manual under Steps for Assessment in Section H: Bladder and Bowel reads: 1. Examine the resident to note the presence of any urinary or bowel appliances. Furthermore under Coding Instructions: Check next to each appliance that was used at any time in the past 7 days. Section H, 100 Appliances includes indwelling catheter as an option to be selected if the resident has an indwelling catheter. Review of Resident #53's medical record revealed the facility admitted the resident on 02/03/2020 with [DIAGNOSES REDACTED]. Further review of the medical record revealed the resident was admitted with an indwelling urinary catheter (an appliance inserted from outside the body through the urethra into the bladder to allow emptying of the bladder). Review of Resident #53's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the resident was not marked on Section H as having an indwelling catheter, and was assessed to always be incontinent of bladder. Review of Resident #53's current Physician order [REDACTED].#53's care plan, dated 02/10/2020, revealed the resident was care planned with a Focus of: the resident has an indwelling Foley catheter due to [DIAGNOSES REDACTED].#53 revealed the resident was in bed with an indwelling catheter noted with yellow urine with no sediment in the tubing, and a dignity bag was in place. Observation on 03/11/2020 at 10:18 AM of catheter care for Resident #53 revealed no concerns. Interview with State Registered Nursing Assistants (SRNA) #1 and #2 who performed the catheter care revealed that the resident had the catheter ever since they have been here. Interview on 03/11/2020 at 10:47 AM with the MDS Coordinator revealed the resident was admitted to the facility from another facility. Per the MDS Coordinator, the resident was admitted with a Urinary Tract Infection, but she stated she did not remember if the resident had a catheter at that time. Upon reviewing the Indwelling Catheter Evaluation that was performed upon admission the MDS Coordinator agreed the resident must have had the catheter upon admission and that it should have been triggered on the MDS. Interview on 03/11/2020 at 4:17 PM with the Administrator revealed they had identified a concern with the accuracy of the MDS. The Administrator stated staff were making sure daily orders were put into the care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review it was determined the facility failed to update the care plan for one (1) of thirty-nine (39) sampled residents (Resident #8). Resident #8's gastrostomy tube ([DEVICE]) (a tube inserted through the belly that brings nutrition directly to the stomach) was removed on 08/01/2019; however, the facility failed to revise the resident's care plan and remove the use of the [DEVICE] for nutrition. The findings include: Review of a facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, not dated, revealed, As the resident remains in the Nursing Home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident . Further review of the policy revealed, The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plan more often based on changes in the resident's condition and/or newly developed health/psycho-social issues. Record review revealed the facility admitted Resident #8 on 06/13/2018 with [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident could not participate in the Brief Interview for Mental Status (BIMS) due to being rarely or seldom understood. Further review of the MDS revealed the resident was not marked as having a [DEVICE] under Section K. Review of Resident #8's Care Plan, dated 01/17/2020, revealed the resident was care planned with a Focus: The resident requires tube feeding (thru [DEVICE]) related to [DIAGNOSES REDACTED]. Review of Resident #8's Physician

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN	**945 WEST RUSSELL STREET ELKHORN CITY, KY 41522**

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) order [REDACTED]. The reason for the order was listed as the tube was discontinued and the resident no longer had a [DEVICE]. Observation of Resident #8 on 03/08/2020 at 2:22 PM revealed the resident was in bed lying on the right side with eyes open; attempted interview resulted in the resident not able to answer questions. No tube pump (equipment to administer feeding thru [DEVICE]) was present. Other observations on 03/09/2020 revealed no tube pump present. Interview on 03/11/2020 at 9:08 AM with Licensed Practical Nurse (LPN) #1 revealed the resident did not have a [DEVICE] and stated the resident had not had the tube in a while. Observation at this time revealed a small healed scar where the [DEVICE] had been. She further stated the resident eats well and received the house supplement and drinks well. Interview on 03/11/2020 at 9:25 AM with the MDS Coordinator revealed she reviews the care plans and updates them when the MDS is due and as needed. She further stated that the nursing staff can also update care plans. Per the MDS Coordinator, I actually reviewed (Resident #8's) care plan yesterday, but I missed the [DEVICE] feeding that was left on it. She further stated that the tube feeding should have been taken off of the care plan. Interview on 03/11/2020 at 4:21 PM with the Administrator revealed the care plan should have been updated after the [DEVICE] was removed.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and a review of facility policy it was determined the facility failed to ensure a resident who needs respiratory care was provided such care consistent with professional standards of practice for one (1) of thirty-nine (39) sampled Residents (Resident #82). A continuous positive airway pressure ([MEDICAL CONDITION]) mask assembly for Resident #82 was observed stored uncovered hanging on the bulletin board in the resident's room. The findings include: A review of the facility policy for [MEDICAL CONDITION] use titled, [MEDICAL CONDITION]/[MEDICAL CONDITION] Home System Use, undated, revealed the policy did not address the storage of the [MEDICAL CONDITION] machine or the [MEDICAL CONDITION] mask/equipment. A review of the medical record for Resident #82 revealed the facility admitted the resident on 11/23/2018 with [DIAGNOSES REDACTED]. A review of the plan of care developed for Resident #82 revealed the resident utilized the [MEDICAL CONDITION] machine from 10:00 PM to 6:00 AM for difficulty breathing and obstructive sleep apnea. Observations of Resident #82's [MEDICAL CONDITION] machine on 03/08/2020 at 2:25 PM, 03/09/2020 at 9:23 AM, and 03/11/2020 at 9:55 AM revealed the [MEDICAL CONDITION] mask apparatus was connected to the machine on a shelf by the resident's bed and the mask apparatus was hanging uncovered on a push pin on a bulletin board above the shelf. An interview with Licensed Practical Nurse (LPN) #2 on 03/11/2020 3:14 PM revealed the LPN was responsible for the care of Resident #82. According to the LPN she had placed the [MEDICAL CONDITION] on the resident at 10:00 PM and removed the [MEDICAL CONDITION] from the resident at 6:00 AM. Further interview with LPN #2 revealed she stored the [MEDICAL CONDITION] mask in a plastic bag and was not aware why the [MEDICAL CONDITION] was not stored in a plastic bag and was hanging on the resident's bulletin board uncovered. An interview with the Director of Nursing (DON) on 03/11/2020 at 10:21 AM revealed the facility did not have a policy addressing storage of the [MEDICAL CONDITION] equipment/mask. However, the DON stated nurses were responsible for cleaning, applying, removing, and placing the mask in a plastic bag for storage when the [MEDICAL CONDITION] was not in use. According to the DON, she made daily rounds to ensure resident equipment is stored correctly and had not identified any concerns with the storage of [MEDICAL CONDITION] masks.