

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320
--	---

(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 An Abbreviated Survey investigating KY#22310 was conducted 10/07/14 and concluded 10/08/14 to determine the facility's compliance with Federal requirements. KY#22310 was unsubstantiated with a deficiency cited at a Scope an Severity of a "D".	F 000		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedures, it was determined the facility failed to ensure the clinical record for one (1) of five (5) sampled residents (Resident #1), was accurate and provided enough information to show the facility knows the status of the individual and provides evidence of the effects of the care provided. It was determined the facility failed to ensure the clinical	F 514	F 514 RECORDS COMPLETE/ACCURATE/ACCESSIBLE The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record shall contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. CRITERIA #1: Resident #1's medical record was revised on 10/24/14 by LPN #1 to include a complete and accurate assessment of the resident's foot wound and communication with the MD as was documented in the incident report dated 10/20/14. CRITERIA #2: An audit of the medical records of residents who currently have (or within the past 30 days have had) skin ulcers/wounds, was completed on 10/28/14 by Director of Nursing and/or designee to determine that documentation in the medical record includes a complete and accurate assessment of any/all skin ulcers/wounds; and any communication with the MD regarding the assessment(s). CRITERIA #3: All licensed nurses have received in-service education on the requirements of State and Federal requirements for medical records, including, but not limited to: ulcer/wound assessment and communication with MD on 11/14/14 by the Director of Nursing. CRITERIA #4: The CQI tool for the monitoring of complete and accurate documentation of ulcers/wounds in the residents' Medical Records shall	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> NHA	TITLE NHA	(X6) DATE 11-5-14
---	--------------	----------------------

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

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 514	<p>Continued From page 1</p> <p>record was complete and accurate related to there was no documentation in the resident's record that described the actual event of maggots found in a wound on the resident's foot on 10/02/14 or the instructions from the physician after that discovery.</p> <p>The findings include:</p> <p>Review of the undated facility policy titled, "Medical Records", revealed a complete active medical record should be maintained for each resident, in accordance with accepted professional practices, standards and applicable laws.</p> <p>Record review revealed the facility admitted Resident #1 on 09/11/14 with diagnoses to include Peripheral Arterial Occlusive Disease, Diabetes Mellitus, Ulcer of Foot, Gangrene and Dementia. Review of the admission Minimum Data Set (MDS) assessment, dated 09/18/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) and required extensive assistance with activities of daily living.</p> <p>Review of the Physician's Orders, dated 09/11/14, included Providone Iodine 10% swab to toes/feet twice daily.</p> <p>Review of Progress Notes, dated 09/30/14, revealed the resident was seen at the surgeon's office on 09/30/14 and review of a Progress Note, dated 10/02/14, revealed surgery was scheduled for amputation of the toes to the left foot on 10/03/14.</p>	F 514	<p>be utilized weekly X 4 weeks, then monthly for 2 months and then quarterly as per established CQI calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, whose members include Medical Director, Administrator, DON, ADON, Medical Records, Therapy Director, Maintenance Director, Business Office Manager, Human Resources, Social Services, Dietary Manager and Housekeeping Supervisor, with updated audit results, at the next monthly meeting.</p> <p>CRITERIA #5: Target Date -</p>	11/14/14	

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 514	<p>Continued From page 2</p> <p>Review of the Nursing Progress Note, dated 09/30/14 and titled "Health Status Note", revealed a new order to hold Coumadin (anticoagulant) until orders received related to surgery. There were no entries for the dates of 10/01/14 or 10/02/14. A Health Status Note, dated 10/03/14 at 4:30 AM, revealed Resident #1 left the facility for surgery and another dated 10/06/14 at 4:42 PM revealed the resident returned to the facility from the hospital per Emergency Medical Services (EMS) with left toes amputated and dressing not to be changed until patient sees physician in two (2) days.</p> <p>Review of the hospital Surgery Record Encounter Notes, dated 10/03/14 at 6:17 AM, revealed Ischemia of one (1) to three (3) toes with maggots. Review of a pre-operative note, dated 10/03/14 at 8:18 AM, revealed "Dressing removed prior to prep by physician. Maggots present on and around all digits. Alcohol and Peroxide poured onto toes to remove maggots. Double Betadine prep following maggot removal". Post operative notes, dated 10/03/14, revealed under the Post-op Skin information: Forty (40) plus maggots present after dressing removed.</p> <p>Review of an Incident/Accident Report which was not part of the clinical record with Resident #1's name, dated 10/02/14 and signed by the Director of Nursing (DON), revealed the time of event was 9:30 AM. The description documentation revealed: "Resident taken to shower room for shower, Certified Nurse Aide (CNA) called Licensed Practical Nurse (LPN) #1 to shower room to undress left foot for shower. When dressing removed a large amount of maggots noted. Resident's foot was sprayed for several minutes with water. Maggots noted to still be in</p>	F 514			

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 514	<p>Continued From page 3</p> <p>wound. MD called and informed. MD ordered to wrap foot securely with maggots inside dressing and send for surgery as scheduled in the AM".</p> <p>Interview with LPN #1, on 10/08/14 at 8:40 AM, revealed Resident #1 had returned from the surgeon's office on 09/30/14 with a wrap covering the left foot. LPN #1 rewrapped the left foot on 10/01/14 after providing the Betadine swab treatment. She stated no maggots were on the resident's foot at that time. She stated however, on 10/02/14 during the morning shower, the wrap was removed from the resident's left foot and she saw maggots. She stated the dressing was "wiggling with them and I cried". LPN #1 stated she "sprayed and sprayed" the resident's foot with water and "the more I sprayed, the more came out". She stated she notified the surgeon and family immediately. The surgeon instructed to keep the foot wrapped to keep the maggots contained and send the resident to the hospital the next morning (10/03/14) for the scheduled surgery for amputation of the toes. She revealed she showed the Assistant Director of Nursing (ADON) over the North Unit, and notified the MDS Coordinator and the Director of Nursing (DON). LPN #1 documented the observation of the maggots on the resident's left foot in the computer nursing notes but was instructed to remove that documentation by LPN #2, who was the ADON of the North Unit. LPN #1 then documented the information on an Event Statement as instructed by LPN #2.</p> <p>Interview with LPN #2, Unit Manager of the North Unit, on 10/08/14 at 9:00 AM, revealed she was aware of the maggot infestation found on Resident #1's left foot on 10/02/14. She revealed</p>	F 514			

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320		
(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 514	<p>Continued From page 4</p> <p>LPN #1 summoned her to the shower room on the North Hall and she observed maggots in the dressing and on the toes of the left foot of Resident #1. LPN #2 asked LPN#1 if the maggots had been placed on the wound for treatment at the surgeon's office on 09/30/14 and LPN #1 did not know. LPN #1 called the surgeon's office and found the maggots were not placed for therapeutic purposes and was instructed to redress the resident's foot and continue with the plan for surgery the next morning. LPN #2 stated she told LPN #1 to take the documentation out of the computer Nursing Notes and document on paper until they could determine if the maggots had been purposefully placed.</p> <p>Additional interview with LPN #2, on 10/08/14 at 10:45 AM, revealed an Incident/Accident Report and Event Statements were not part of a resident's record. The Incident Reports were not kept in a resident's record, therefore, Resident #1's record was not accurate and complete without documentation of the discovery of maggots on the resident's foot wound and instructions of the surgeon following the discovery.</p> <p>Interview with the Director of Nursing (DON), on 10/08/14 at 2:00 PM, revealed she was made aware of the maggot infestation found on Resident #1's foot on 10/02/14. She stated an investigation was initiated to pin point what had happened and it was determined the maggots were not placed for therapeutic treatment by the surgeon's office. She revealed the physician was aware and had instructed to keep the foot covered and "we did it". The DON stated an Event Statement or Incident Report was not in the</p>	F 514			

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

PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 514	Continued From page 5 resident's record and the information on those records should have been in the resident's record. Interview with the Administrator, on 10/08/14 at 3:20 PM, revealed she would expect a resident's record to be kept in accordance with Professional Standards.	F 514			