

MAY 10 2011

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 04/22/2011  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/11/2011
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NAME OF PROVIDER OR SUPPLIER  OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359
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F 000	INITIAL COMMENTS  Amended Statement of Deficiencies  An abbreviated standard survey was initiated on 04/10/11 and concluded on 04/11/11 investigating KY00016105, KY00016103, KY00015780, KY00016104 and KY00016221. KY00016105, KY00016104 and KY00016221 were unsubstantiated with no deficiencies cited. KY00016103 and KY00015780 were substantiated with deficiencies cited.  483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to follow the comprehensive plan of care regarding administration of medications for one (1) resident (Resident #4) of the six (6) residents sampled.  The findings include:  Interview with the Director of Nurses, on 04/10/11 at 12:45pm, revealed on 02/21/11 an LPN gave a syringe of Haldol to a Nursing Assistant to administer the medication to Resident #4. This was witnessed by another nursing assistant.  Review of the closed clinical record for Resident #4 revealed an admission date of 01/25/11 and a discharge date of 03/14/11. Current diagnoses	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."  F282  1. Resident #4 no longer resides at Owenton Manor. Resident #4 was discharged to a personal care home on April 14, 2011. The LPN no longer works at the facility. Last date of employment was March 11, 2011.  2. A review of current residents was conducted on or before March 17, 2011 by the Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers. Care plans were updated during the review to reflect current status and to ensure residents plan of care being followed by qualified persons.  3. The nursing staff and MDS Coordinator were re-educated on or before March 13, 2011 by the Director of Nursing Services and the Assistant	4/12/11
F 282 SS=D		F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X</i> <u>Paul Shum</u>	TITLE <i>X</i> <u>Administrator</u>	(X6) DATE <i>X</i> <u>04/11/11</u>
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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.

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F 282	<p>Continued From page 1</p> <p>were Bipolar Disorder, Dysphagia, Muscle Weakness and Chronic Obstructive Pulmonary Disease. The Admission MDS dated 01/31/11 indicated the resident was extensive assistance with all activities of dally living and was not interviewable with a coding of 2 (0-7 severely impaired) in cognitive abllitles.</p> <p>Review of the comprehensive plan of care indicated the resident displayed disruptive behaviors and was to receive medications per the physician and monitor the effectiveness of the medication. The physician's orders dated 02/01/11 through 02/28/11 revealed the resident was to receive Haldol 5mg three times a day and Haldol 10mg IM (intramuscular) every 4 hours as needed. However, the Haldol 10 mg had been discontinued by the Psychiatrist on 02/03/11 and was not reordered until 02/25/11.</p> <p>Review of the February 2011 medication administration record (MAR) revealed no documentation of an as needed dose of Haldol being administered. Review of the nurses notes did not reveal any documentation of Resident #4's behavior that required the as needed dose of Haldol or the effectiveness of the medication.</p> <p>Interview with the LPN on 04/11/11 at 10:15am revealed the LPN did not follow the plan of care when she failed to document the behaviors that required the Haldol, monitor for effectiveness or provide the resident with a medication that was ordered by the physician. In addition, the LPN failed to follow the plan of care by allowing a nursing assistant to administer a injectable medication to Resident #4.</p> <p>Interview with the Director of Nurses, on 04/11/11</p>	F 282	<p>Director of Nursing Services. The education included following the residents plan of care.</p> <p>4. The Director of Nursing Services, Assistant Director of Nursing Services or Unit Managers will review 5 residents plan of care per week for 4 weeks then monthly for 2 months. The review will include qualified persons following the plan of care. The results will be reported by the Director of Nursing Service or Assistant Director of Nursing Services to the Performance Improvement Committee monthly for three (3) months for review and recommendations.</p>	
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F 282	Continued From page 2 at 1:00pm, revealed after review of the clinical record there was no order for the as needed dose of Haldol on 02/21/11. In addition, the DON stated Nursing Assistants are not allowed to give injections or administer medications at any time.  Review of the LPN job description, dated October 2003 revealed .. essential position duties include: 1. monitors resident's condition and provides professional nursing services as indicated per physician orders and care plan in accordance with state and federal regulations and SunBridge Policies and Procedures.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to follow physician orders for two (2) residents (#2 and #4) of the six (6) residents sampled. The facility did not provide respiratory treatments as ordered by the physician for Resident #2 and administered a medication to Resident #4 without a physician's order and allowed a nursing assistant to perform the injection.  The findings include:	F 309	F309  1. Resident #4 was discharged from facility on April 14, 2011. The LPN no longer works at the facility. Last date of employment was March 11, 2011. Resident #2 was discharged from the facility on March 30, 2011.  2. Current resident's physician orders were reviewed by Unit Managers on or before March 13, 2011. Identified residents had notifications and interventions completed on or before March 13, 2011.  3. Nursing staff were re-educated by the Director of Nursing Services or Assistant Director of Nursing Services on or before March 13, 2011. Education included following the plan of care, scope of practice, abuse and reporting, physician notification and following physician's orders. Medication capabilities observation was completed on licensed	4/12/11

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F 309	<p>Continued From page 3</p> <p>Review of the facility policy regarding General Dose Preparation and Medication Administration dated 05/01/10 revealed 1. prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to: facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident; confirm that the MAR reflects the most recent medication order; and document the necessary medication administration information on appropriate forms.</p> <p>Interview with the Director of Nursing on 04/10/11 at 12:45pm revealed on 02/21/11 an LPN gave a syringe of Haldol to a nursing assistant (CNA #1) to administer an IM (intramuscular) injection to Resident #4.</p> <p>Review of the closed record for Resident #4 revealed an admission date of 01/25/11 and a discharge date of 03/14/11 with diagnoses of Bipolar Disorder, Dysphagia, Muscle Weakness, and Chronic Obstructive Pulmonary Disease. Review of the Physician orders dated 02/01/11 through 02/28/11 revealed an order for Haldol 5mg three times a day and an order for Haldol 10mg IM every 4 hours as needed (PRN) had been discontinued by the Psychiatrist on 02/03/11. The Haldol, PRN dose, had not been reordered until 02/25/11. Review of the February 2011 MAR did not reveal any documentation that the Haldol had been administered on 02/21/11.</p> <p>Interview on 04/10/11 at 1:10pm, with CNA #2, who witnessed the incident, revealed the LPN gave the syringe to the CNA#1, the nursing</p>	F 309	<p>nurses by the Assistant Director of Nursing Services on or before March 13, 2011.</p> <p>4. The Director of Nursing Services or Assistant Director of Nursing Services or Unit Managers will review physician's orders and medication administration records for completion and physician notification on 5 residents weekly times 4 weeks then monthly for 2 months. The Director of Nursing Services or Administrator will conduct facility observation rounds 5 times a week to assess staff scope of practice being followed and interview staff regarding abuse. The results will be reported by the Director of Nursing Service or Assistant Director of Nursing Services to the Performance Improvement Committee monthly for three (3) months for review and recommendations.</p>	

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F 309	Continued From page 4 assistant wiped Resident #4's arm and administered the injection. The LPN told the two nursing assistants "you can't tell anyone because we can lose our jobs".  Interview on 04/11/11 at 10:15am, via the telephone, with the LPN revealed the unit was hectic and the nursing assistants reported Resident #4 was going crazy. The nursing assistant grabbed the syringe out of the nurses hand and gave the injection to the resident at the medication cart. This happened to fast to stop her. At this time the LPN was requested to come to the facility to talk. The LPN arrived 15 minutes later. Interview continued. The LPN clarified the above statements as the CNA did not grab the syringe from her hand but from the cart where it was lying. The LPN stated there were three residents in front of the nurses station and going kind of crazy. The two nursing assistants stated she had to do something about these residents. The LPN drew up Haldol in a syringe and CNA #1 identified herself as a nursing student. The LPN let CNA #1 administer the injection to Resident #4. The LPN stated she was not a nursing instructor nor was she hired by the facility for that purpose. The LPN did not know if CNA #1 was indeed a nursing student or not. The LPN further stated she did not check the physician's orders to see if Resident #4 had an order for Haldol PRN, did not document the Haldol was given and was not aware the order had been discontinued on 02/03/11 until this interview. Review of the 02/2011 MAR with the LPN revealed all days and shifts were X'd out for the Haldol PRN dose. The LPN stated that meant the medication order was not in effect. Upon further interview the LPN could not identify the five routes of medication administration.	F 309		

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F 309	<p>Continued From page 5</p> <p>Interview with CNA #1, via the telephone, on 04/11/11 at 10:35am revealed it was a normal night. Resident #4 was in bed and she did not administer the injection.</p> <p>Interview with the Director of Nurses on 04/11/11 at 1:00pm revealed there was no order for the Haldol to be give as needed only the routine dose three times a day. In addition, it is not the facility's policy for nursing assistants to administer injections to residents. The DON further stated CNA #1 denied the incident there were two staff who stated the incident occurred.</p> <p>Interview with the Administrator on 04/11/11 at 1:55pm revealed the LPN stated during interview she allowed the CNA #1 to administer the injection to Resident #4. The Administrator stated the two nurses on the 11-7 shift do not have direct supervision but supervise themselves.</p> <p>Review of the medical record revealed, Resident #2's date of birth was 05/21/47. He/she was admitted to the facility on 10/19/10 with admitting diagnoses of Disease of the Blood and Blood Forming Organs, Anxiety, Anemia, Hypertension, Congestive Heart Failure, Malignant Neoplasm of the Larynx, Palliative Care, and Chronic Obstructive Pulmonary Disease. He/she was a Hospice patient now in the hospital and is to be discharged home after the hospital stay.</p> <p>Review of the treatment record of Resident #2 on 04/11/11 at 10:20am revealed from March 3, 2011 through March 11, 2011 there was no documentation on the treatment record that the resident received physician ordered breathing treatments. Resident #2 had Mucomyst</p>	F 309		
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F 309	<p>Continued From page 6</p> <p>treatments ordered by the physician to be given twice a day at 10:00am in the morning and at 10:00pm in the evening.</p> <p>Interview with the 100 unit supervisor on 04/11/11 at 10:35am revealed the manger suggested the resident may have been in the hospital. Further review of the treatment record revealed during this same time frame, the respiratory rate, breath sounds and appearance of Resident #2's sputum were documented.</p> <p>Interview with the 100 hallway unit manager on 04/11/11 at 12:00pm revealed the flow sheet is a facility tool to document the respiratory status of residents with special respiratory needs to include the respiratory rate, lung sounds, and the appearance of sputum. Record review revealed up to eight (8) days of information was missing from the treatment record (TAR).</p> <p>Interview with the 100 unit manager, on 04/11/11, also revealed she was in the process of reeducating her staff to the importance of documenting.</p>	F 309		
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