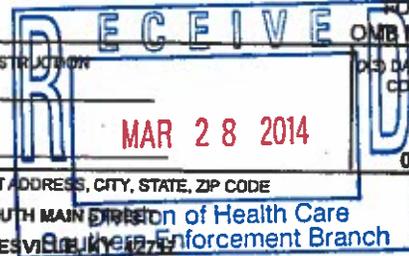


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 03/21/2014
FORM APPROVED
OMB NO. 0938-0391



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42719 Division of Health Care Enforcement Branch | |
| (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 health survey was conducted on 02/17-20/14. Deficient practice was identified with the highest scope and severity at "G" level, with no opportunity to correct. The facility failed to ensure services were provided in accordance with the plan of care and failed to ensure residents received supervision and assistive devices for one (1) of seventeen (17) sampled residents (Resident #6). On 02/11/14, at approximately 7:00 PM, two CNAs transferred Resident #6 to bed; however, staff failed to use a mechanical lift for the transfer. Approximately two hours later, the Charge Nurse assessed the resident to have swelling and discoloration of the right shoulder area. The facility transferred Resident #6 to the Emergency Room and the resident was diagnosed with and a torn pectoral muscle of the right arm/chest area. | F 000 | Plan of Correction Cumberland Valley Manor Standard Survey 2/20/14 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. | |
| F 257 SS=E | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility's policy, Room Temperature Levels, it was determined the facility failed to ensure temperature levels were maintained between 71 and 81 degrees Fahrenheit in the Station III Dining Room in order to provide comfortable and safe air temperatures levels for eight (8) of eight | F 257 | F 257 Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81°F. | |

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

TITLE

(X8) DATE

[Signature]

Administrator

03/28/14

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.

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| F 257 | <p>Continued From page 1</p> <p>(8) unsampled residents. Observation of the breakfast meal on 02/18/14 revealed eight (8) unsampled residents were eating in the Station III Dining Room. The air temperature in the Station III Dining Room was obtained and was noted to be 67 degrees Fahrenheit.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Room Temperature Levels (undated) revealed it was the facility's policy to maintain an optimal room temperature range of 71 to 81 degrees Fahrenheit (F).</p> <p>Observation of the room air temperature in the Station III Dining Room was taken on 02/18/14 at 8:24 AM and revealed the temperature, during the morning meal, was 67 degrees F. Further observations revealed three of the eight residents seated in the Dining Room were covered with blankets.</p> <p>A group interview was conducted on 02/18/14 at 11:30 AM with six alert and oriented residents. During the interview, three of the residents complained that the Station III Dining Room was often "cold" during meals.</p> <p>An interview on 02/20/14 at 4:56 PM, with the Infection Control Nurse revealed she occupied the office next to the Station III Dining Room. According to the Infection Control Nurse, she was aware the thermostat in the office could affect the temperature of the Dining Room. She further stated her office was too hot at times and she would adjust the thermostat. The Infection Control Nurse was not aware of the required air temperature range in the facility.</p> | F 257 | <p>Criteria 1: The thermostat in Dining Room #3 was adjusted to between 71 - 81°F, and a lock out box was placed over the thermostat in the classroom to determine that only designated staff can adjust the temperature.</p> <p>Criteria 2: All thermostats in common areas of the facility were inspected by the Maintenance Director/Administrator on 02/21/14 to determine that the temperature in all common areas was maintained between 71 - 81°F. All areas were in compliance with these temperatures.</p> <p>Criteria 3: The maintenance staff were provided in-service education by the Administrator on 02/21/14, on the need to monitor the thermostats in resident common areas weekly to determine that temperatures are maintained between 71 - 81°F, and are documenting all temperatures that fall outside of the these required parameters. Any discrepancies are to be brought to the attention of the administrator via verbal report, and addressed as indicated.</p> | | |

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| F 257 | Continued From page 2 Interview conducted with the Maintenance Director on 02/20/14 at 1:30 PM revealed the Maintenance Department staff monitored room temperatures on a daily basis and adjustments were made if necessary. According to the Maintenance Director, he was not aware the Dining Room temperature was 67 degrees Fahrenheit on 02/18/14, and had not been maintained between 71 and 81 degrees F. Further interview with the Maintenance Director revealed there was a thermostat located in the Dining Room and a thermostat located in a classroom adjacent to the Station III Dining Room. The Maintenance Director stated if staff adjusted the thermostat in the classroom, it could affect the temperature in the Dining Room. The Maintenance Director stated even though the room temperatures were monitored on a daily basis, he did not maintain a log of the room temperatures, and was not aware of any resident concerns related to the air temperature. | F 257 | Criteria 4: The CQI indicator for the monitoring of facility temperatures maintained in the range of 71-81°F will be utilized monthly X 2 months then quarterly as per the CQI calendar under the supervision of the Environmental Supervisor.. Failure to achieve the required indicator threshold will result in development and implementation of a Plan of Action and a repeat of the indicator within 1-2 months to verify effectiveness. Criteria 5: March 3, 2014 | | |
| F 282 SS=G | 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 observation, interview, record review, and review of the facility's Care Plan Policy Statement, the Certified Nurse Aide (CNA) Care Plan Record policy, and the facility's investigation, it was determined the facility failed to ensure | F 282 | F282 Comprehensive Care Plans. The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care. | | |

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| F 282 | <p>Continued From page 3</p> <p>services were provided in accordance with the written plan of care for one (1) of seventeen (17) sampled residents (Resident #6). The facility assessed Resident #6 to require staff support with transfers and had care plan interventions for a mechanical lift to be used during all transfers. However, facility staff failed to utilize a mechanical lift during a transfer on 02/11/14 at approximately 7:00 PM. On 02/11/14 at approximately 9:00 PM, staff assessed the resident to have bruising and swelling of the right arm/shoulder. The facility transferred the resident to the Emergency Department (ED) for evaluation and treatment. Review of the Emergency Department's Physician's Progress Notes revealed the resident was diagnosed with a torn right pectoral muscle.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy Statement (not dated) revealed a Comprehensive Plan of Care would be developed by the interdisciplinary team based on the completion of the comprehensive Minimum Data Set (MDS) assessment. The policy statement did not address implementation of the residents' care plans.</p> <p>Review of the Certified Nurse Aide (CNA) Care Plan Record policy (no date) revealed the care plan would be utilized to identify/document each resident's daily care needs. The policy further noted the CNA care plan would provide information regarding the amount of assistance the resident required for transfers and any assistive devices to be used for mobility.</p> <p>Review of the Quarterly MDS assessment dated</p> | F 282 | <p>Criteria 1: -The MD and RP for Resident #6 were notified of the bruising/injury identified during assessment. Resident #6 was transferred to the Emergency Room for further assessment and treatment.</p> <p>-Observations of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for resident #6 as follows: with each transfer for 24 hours, then done randomly with a transfer once per shift for 3 days, then done randomly with a transfer once per day for 3 days, as performed by the charge nurses and/or administrative nurses.</p> <p>-Daily skin assessments will be performed for resident #6 by the charge nurses for 7 days, then weekly thereafter to monitor the status of the bruising/injury. The MD will be notified of any changes in healing status.</p> <p>-Disciplinary action was implemented per facility policy for the identified staff who failed to utilize the mechanical lift in accordance with the care plan.</p> | | |

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| F 282 | <p>Continued From page 4</p> <p>12/19/13, revealed the facility assessed Resident #6 to require total assistance of two staff persons for transfers. The MDS further revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan with a review date of 12/20/13, revealed the facility had addressed the resident's alteration in mobility. Interventions included using a mechanical lift for all transfers. Review of the CNA care plan dated February 2014 revealed Resident #6 was non-weight bearing and staff was directed to use a "Viking" lift (a mobile device used for lifting) for transfers.</p> <p>Review of the February 2014 physician's orders revealed staff was to transfer Resident #6 with the use of a mechanical lift.</p> <p>Review of the facility's investigation, dated 02/12/14 at 9:00 AM, revealed facility staff failed to utilize a mechanical lift during transfer of Resident #6 from the chair to the bed on 02/11/14 at approximately 7:00 PM. Continued review of the investigation revealed on 02/11/14 at approximately 9:00 PM, after staff transferred the resident to bed, Registered Nurse (RN) #3 assessed Resident #6 and noted the resident had a newly identified discolored area and edema of the right shoulder area. Further review revealed the facility transferred the resident to the Emergency Department (ED) for further evaluation and treatment. According to the Emergency Department's Physician's Report, the resident had a large amount of "ecchymosis" (escape of blood into the tissues from ruptured blood vessels, marked by a purple discoloration</p> | F 282 | <p>Criteria 2: -Head to toe skin assessments were completed by the administrative and charge nurse staff for all residents to identify any changes in skin status, or unidentified bruises that had not yet been addressed. No areas were identified that had not been addressed.</p> <p>-The care plans and C.N.A care plans for all residents assessed to require mechanical lift use, were reviewed to determine that this intervention was addressed as indicated.</p> <p>-Observation of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for all residents requiring this intervention by the charge nurses and/or administrative nurses randomly once per day for 3 days.</p> <p>-Compliance rounds are conducted weekly by the Administrative/Charge Nurse staff to monitor nursing staff compliance with the care plan interventions.</p> | | |

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| F 282 | <p>Continued From page 5</p> <p>of the skin) and a firm/swollen area on the right shoulder. Further review of the ED Report revealed no fractures were identified and the resident was diagnosed with a right torn pectoral muscle "probably associated with moving or pulling the patient up in bed or the wheelchair."</p> <p>Observation of a skin assessment conducted by facility staff on 02/18/14, at 11:10 AM, revealed Resident #6 had a raised area measuring 13 centimeters (cm) by 10 cm on the anterior area of the right shoulder, fading dark purple bruising measuring 3.5 cm by 9 cm near the right axilla; a 22 cm by 10.5 cm yellowish fading discoloration across the resident's upper chest area; a 16 cm yellow fading area extending down the resident's right upper arm; and a 16 cm by 10 cm yellow/purplish area on the right side under the resident's rib cage.</p> <p>Observation at 12:10 PM on 02/18/14, revealed CNAs #7 and #10 transferred Resident #6 from the bed into a Broda chair (chair that reduces pressure and provides long-term sitting support) using the mechanical lift device.</p> <p>Interview conducted with CNA #1 on 02/18/14, at 3:55 PM, revealed he had been trained to review the CNA care plan at the beginning of each shift. However, the CNA stated he had not looked at the care plan "in a while" and did not know Resident #6 was to be transferred using a mechanical lift. CNA #1 stated he and CNA #2 transferred Resident #6 from the Broda chair to the bed at approximately 7:00 PM on 02/11/14. CNA #1 stated he and CNA #2 each placed an arm underneath the resident's arms and their hand on the resident's waist and assisted the resident onto the bed. CNA #1 stated during the</p> | F 282 | <p><u>Criteria 3: -In-service education was provided for the nursing staff by the DON/ADON/Restorative Coordinator on the following:</u></p> <p>-Correct and consistent use of the mechanical lift in accordance with the resident care plan.</p> <p><u>-Provision of all resident care in accordance with the care plan, with notification of the charge nurse if the nursing assistants should identify any obstacle that would prevent them from being able to comply with the care plan.</u></p> <p>-Safe transfer technique for residents who do not require use of a mechanical lift.</p> <p>-Immediate reporting of any identified changes in skin status, including bruising, to the charge nurse by the nursing assistants, and to the MD and RP by the charge nurses.</p> <p>-Licensed nurses were provided in-service education by the DON/ADON/Wound Nurse on the completion and documentation of thorough skin assessments, with measurements of any identified bruising for monitoring purposes. Any changes in skin status or declines in the healing status of</p> | | |

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| F 282 | <p>Continued From page 8</p> <p>transfer on 02/11/14, he observed a fading bruise on the resident's right upper arm that had been caused by the application of a blood pressure cuff from "about" a week earlier. The CNA stated he did not observe any new bruises at the time of the transfer. CNA #1 also stated the resident did not exhibit or verbalize pain during or after the transfer.</p> <p>Interview conducted with CNA #2 on 02/18/14, at 4:15 PM, revealed she also had been trained to follow the CNA care plan when she transferred a resident. CNA #2 stated she knew Resident #6 was to be transferred at all times with a mechanical lift. She stated that she assisted CNA #1 to transfer Resident #6 from the Broda chair to the bed on 02/11/14, at approximately 7:00 PM. CNA #2 stated Resident #6 was transferred using a two-person transfer and the mechanical lift had not been used. She further stated she did not tell CNA #1 the resident was supposed to be transferred with the mechanical lift and she did not know why the lift had not been used.</p> <p>Interview conducted with the Director of Nursing (DON) on 02/19/14 at 11:50 AM, revealed the Charge Nurse was responsible to monitor care being provided by the CNAs and to ensure the care was in accordance with the resident's plan of care. The DON stated RN #3 called her at home after discovering the bruises on the resident's right shoulder area when the nurse was preparing to administer an injection to the resident on 02/11/14. The DON stated the nurse reported the resident did not complain of pain, but the bruising was discovered after the resident pulled his/her gown down below his/her right shoulder and breast area.</p> | F 282 | <p>bruises are to be reported to the physician.</p> <p>Criteria 4: -A CQI Meeting with the Medical Director and CQI team was held on 2-13-14 to review the facility investigation and the Plan of Correction</p> <p>-The CQI indicator for the monitoring of provision of resident care in accordance with the care plan (such as use of lifts, type and number of staff assistance, use of devices, dietary restrictions etc.) will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. Failure to achieve the established threshold will result in development and implementation of a Plan of Action, and a repeat of the indicator within 1-2 months to verify effectiveness.</p> <p>Criteria 5: March 3, 2014</p> | |

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| F 282 | <p>Continued From page 7</p> <p>Interview conducted on 02/19/14, at 1:50 PM with RN #2 revealed she was the Charge Nurse for Station 1, the unit where Resident #6 resided. She stated her responsibilities included monitoring resident care. RN #2 stated she periodically reminded the CNAs to read the residents' CNA care plans to ensure they knew what care needs the resident required. RN #2 stated she also observed staff providing resident care when she often walked by resident rooms. The RN stated she had observed staff transferring residents, but had not had the opportunity to observe the CNAs transfer Resident #6.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/20/14, at 9:05 AM, revealed she was responsible for orientation with new employees and competency skills checks annually to evaluate staff's ability to provide resident care. LPN #2 stated transfer procedures, following the care plan, and mechanical lift procedures were included in the training and annual competency skills checks. LPN #2 also stated she conducted "spot checks" daily to verify residents were being transferred according to their individual plan of care and she had not identified any problems.</p> <p>Interview with the facility's Compliance Officer on 02/20/14, at 4:00 PM, revealed the facility did not have a specific policy/procedure related to implementation of the resident's written plan of care. The Compliance Officer stated random audits were conducted by the administrative nurses to monitor direct care staff to ensure care needs were provided according to the resident's individual care plan. The Compliance Officer stated no problems had been reported</p> | F 282 | | |

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| F 282 | Continued From page 8 concerning resident transfers prior to the incident involving Resident #6. | F 282 | | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT 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, interviews, record reviews, and review of the facility's policies, Investigation Report, and the Emergency Department (ED) Record and the Physician's Progress Notes, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents was provided for one (1) of seventeen (17) sampled residents (Resident #6). Review of the Comprehensive Care Plan and the Certified Nurse Aide (CNA) Care Plan revealed the facility assessed Resident #6 to require the total assistance of two staff persons and the use of a mechanical lift for all transfers. However, facility staff failed to transfer Resident #6 from the chair to the bed with the assistance of a mechanical lift on 02/11/14 at approximately 7:00 PM. On 02/11/14, at approximately 9:00 PM, after staff had transferred the resident from the chair to the bed, a nurse entered the resident's room to monitor the resident's blood glucose | F 323 | F 323 Accidents and Supervision The facility must ensure that the resident environment remains as free of accident hazards as is possible. Criteria 1: -The MD and RP for Resident #6 were notified of the bruising/injury identified during assessment. Resident #6 was transferred to the Emergency Room for further assessment and treatment. -Observations of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for resident #6 as follows: with each transfer for 24 hours, then done randomly with a transfer once per shift for 3 days, then done randomly with a transfer once per day for 3 days, as performed by the charge nurses and/or administrative nurses.. | | |

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| F 323 | <p>Continued From page 9</p> <p>level. At that time, the resident reached over with his/her left hand and pulled the gown down from his/her right shoulder. The nurse observed the resident's right shoulder was swollen and bruised. The facility transferred Resident #6 to the Emergency Department (ED) for further evaluation and treatment, and according to the ED Physician's Progress Note dated 02/11/14, Resident #6 had sustained a torn pectoral muscle of the right shoulder area.</p> <p>In addition, observations on 02/18/14 at 1:00 PM revealed the hot water temperatures in the women's shower room on Station II was 132 degrees Fahrenheit (F) (22 degrees above the acceptable temperature range); the hot water temperature in the men's shower room on Station II was 120 degrees Fahrenheit (10 degrees above acceptable temperature range); and the hot water temperature in resident room 221 was observed to be 122 degrees F (12 degrees above the acceptable temperature range). Additional observations of the women's and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature in the areas fluctuated from 90 degrees to 117 degrees F. Further observation on 02/18/14 at 1:30 PM, revealed the hot water temperature at the mixing valve for the Station II hallway was 120 degrees (10 degrees above the acceptable temperature range).</p> <p>The findings include:</p> <p>Review of the Mechanical Lift policy (no date) revealed a safe working environment would be provided by utilizing a lift transfer system as deemed appropriate based on the resident's</p> | F 323 | <p>-Daily skin assessments will be performed for resident #6 by the charge nurses for 7 days, then weekly thereafter to monitor the status of the bruising/injury. The MD will be notified of any changes in healing status.</p> <p>-Disciplinary action was implemented per facility policy for the identified staff who failed to utilize the mechanical lift in accordance with the care plan.</p> <p>-The temperature on the water heaters servicing Hall 2 was immediately turned down upon identification of the elevated levels. The necessary part was ordered and replaced by maintenance on 02/21/14.</p> <p>Criteria 2: -Head to toe skin assessments were completed by the administrative and charge nurse staff for all residents to identify any changes in skin status, or unidentified bruises that had not yet been addressed. No areas were identified that had not been addressed.</p> | | |

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

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| F 323 | <p>Continued From page 10</p> <p>comprehensive assessment and the resident care planning process. The policy noted facility staff was required to use the mechanical lift equipment when specified by the resident assessment and care plan.</p> <p>An interview with the Administrator on 02/20/14 at 3:47 PM revealed the facility did not have a written policy that directed staff how and/or when to monitor water temperatures. However, according to the Administrator, it was the facility's procedure for the Maintenance Department to check the water temperatures on a daily basis in resident care areas and to document the temperature on the preventive maintenance checklist for each month. The Administrator stated the facility's Maintenance Department attempted to maintain the water temperatures between 100 and 110 degrees Fahrenheit (F).</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 10/05/10 with diagnoses including Alzheimer's disease, Arthropathy, Vertigo, Reactive Confusion, and Coronary Artery Disease with graft. Review of the Quarterly Comprehensive Assessment dated 12/19/13, revealed the facility assessed Resident #6 to require total assistance of two staff members for transfers and a wheelchair was used for mobility/locomotion. The MDS further revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan reviewed/updated on 12/20/13, revealed the facility addressed the resident's alteration in mobility related to a history of falls and diagnoses</p> | F 323 | <p>-The care plans and C.N.A care plans for all residents assessed to require mechanical lift use, were reviewed to determine that this intervention was addressed as indicated.</p> <p>-Observation of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for all residents requiring this intervention by the charge nurses and/or administrative nurses randomly once per day for 3 days.</p> <p>-Water temperatures were tested throughout the facility, with all other temperatures determined to be within the required parameters.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility and to develop and implement a Plan of Action for any identified issues. The Safety Committee findings are presented to the QA Committee for review.</p> | | |

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

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| F 323 | <p>Continued From page 11</p> <p>of Alzheimer's and Reactive Confusion. Interventions included instructing the resident on appropriate use of assistive/supportive devices; to verbally remind the resident not to ambulate or transfer without assistance; and to use a mechanical lift for all transfers. Further record review revealed the February 2014 CNA care plan indicated the resident was non-weight bearing and required the use of a "Viking" lift (a mobile device used for lifting) for transfers.</p> <p>Review of the facility's Investigation Report dated 02/12/14, at 9:00 AM, revealed after the ED physician contacted the resident's attending physician regarding the resident's injury, the resident's attending physician contacted the facility to inform the Administrator of the injury to Resident #6's shoulder. The facility initiated an investigation on 02/12/14 and interviewed all staff who had provided care for Resident #6 from 02/06-11/14. Based on the findings of the facility's investigation, the facility determined Certified Nurse Aide (CNA) #1 and CNA #2 had transferred Resident #6 from a Broda chair (chair that reduces pressure and provides long-term sitting support) to the bed on 02/11/14 at approximately 7:00 PM. However, according to the facility's investigation, CNAs #1 and #2 failed to follow the Plan of Care that had been developed for Resident #6 as they failed to use a mechanical lift when they transferred the resident to bed. The investigation further revealed when Registered Nurse (RN) #3 entered Resident #6's room on 02/11/14 at approximately 9:00 PM to monitor the resident's blood glucose levels, the resident pulled his/her gown down from the right shoulder area with his/her left hand. The nurse observed "new" bruising and swelling to the resident's right shoulder area.</p> | F 323 | <p>Criteria 3: -In-service education was provided for the nursing staff by the DON/ADON/Restorative Coordinator on the following:</p> <ul style="list-style-type: none"> -Correct and consistent use of the mechanical lift in accordance with the resident care plan.-Provision of all resident care in accordance with the care plan, with notification of the charge nurse if the nursing assistants should identify any obstacle that would prevent them from being able to comply with the care plan. -Safe transfer technique for residents who do not require use of a mechanical lift. -Immediate reporting of any identified changes in skin status, including bruising, to the charge nurse by the nursing assistants, and to the MD and RP by the charge nurses. -Licensed nurses were provided in-service education by the DON/ADON/Wound Nurse on the completion and documentation of thorough skin assessments, with measurements of any identified bruising for monitoring purposes. Any changes in skin status or declines in the healing status of | | |

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

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| F 323 | <p>Continued From page 12</p> <p>Observation of a skin assessment conducted by facility staff on 02/18/14, at 11:10 AM, revealed Resident #6 had a raised area measuring 13 centimeters (cm) by 10 cm on the anterior area of the right shoulder; fading dark purple bruising measuring 3.5 cm by 9 cm near the right axilla; a 22 cm by 10.5 cm yellowish fading discoloration across the resident's upper chest area; a 16 cm yellow fading discolored area extending down the resident's right upper arm; and a 16 cm by 10 cm yellow/purplish area on the right side under the resident's rib cage.</p> <p>Review of documentation by nursing staff in Resident #6's medical record dated 02/11/14, at 9:04 PM, revealed RN #3 entered the resident's room to assess the resident's blood glucose level and noted the resident had discoloration and edema of the right shoulder. Further review revealed RN #3 notified the physician and arranged for the resident to be transferred to the hospital's ED for further evaluation and treatment.</p> <p>Review of the ED record dated 02/11/14, revealed Resident #6 was assessed to have a large amount of ecchymosis (bruising) and a "firm/swollen" area of the right shoulder. X-rays obtained at the ED revealed no evidence of a fracture or dislocation of the right shoulder. Further review of the ED report revealed the resident was admitted to the hospital on 02/11/14 for observation.</p> <p>Review of Resident #6's Attending Physician's Progress Note, dated 02/11/14, revealed the physician assessed Resident #6 to have a hematoma (bruising) to the right anterior chest with bruising to the right upper arm. Further</p> | F 323 | <p>bruises are to be reported to the physician.</p> <p>-The maintenance staff have received in-service education by the administrator on 02/21/14 regarding the need to inspect the water heater units monthly to determine they are maintaining water temperatures within the required parameters, and to test water temperatures randomly throughout the facility in accordance with the preventive maintenance logs.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility and to develop and implement a Plan of Action for any identified issues. The Safety Committee findings are presented to the QA Committee for review.</p> <p>Criteria 4: A CQI Meeting with the Medical Director and CQI team was held on 2-13-14 to review the facility investigation and the Plan of Correction</p> | | |

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

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| F 323 | <p>Continued From page 13</p> <p>review of the Physician's Progress Note revealed the cause of the bruising "appeared to be a torn muscle/tendon." The physician further noted the tear was probably associated with moving or pulling the resident up in bed or a wheelchair.</p> <p>Interview conducted with CNA #1 on 02/18/14, at 3:55 PM, revealed staff should review the CNA care plan each shift to determine the care needs of each resident. According to CNA #1, the CNA care plan included the requirements staff was to follow for each resident's transfer. CNA #1 stated he had not looked at Resident #6's care plan "in a while" and did not know a mechanical lift was to be used for transfers for Resident #6. CNA #1 stated he and CNA #2 transferred Resident #6 from the Broda chair to the bed at approximately 7:00 PM on 02/11/14. CNA #1 stated he and CNA #2 had placed one arm underneath the resident's arms and placed a hand on the resident's waistband, and assisted the resident to transfer from the chair to the bed. CNA #1 confirmed he did not see any bruises or swelling on the resident's right shoulder area. CNA #1 further stated the resident did not indicate any injury or pain had occurred during the transfer.</p> <p>Interview conducted with CNA #2 on 02/18/14, at 4:15 PM, revealed she was aware Resident #6 was to be transferred at all times with a mechanical lift. CNA #2 stated she assisted CNA #1 to transfer Resident #6 from the Broda chair to the bed on 02/11/14, at approximately 7:00 PM and a mechanical lift had not been used during the transfer. CNA #2 stated she did not tell CNA #1 staff was to use a mechanical lift when they transferred Resident #6 and offered no explanation as to why they had not used the mechanical lift.</p> | F 323 | <p>-The CQI indicator for the monitoring of provision of resident care in accordance with the care plan (such as use of lifts, type and number of staff assistance, use of devices, dietary restrictions etc.) will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>-The CQI indicator for the monitoring of facility water temperatures within the required range of 100-110°F will be utilized monthly X 2 months, and then every six months as per the established CQI calendar under the supervision of the Maintenance Director. Water temperatures will also be checked and documented daily by maintenance or designated staff.</p> <p>- Failure to achieve the established threshold for the CQI indicator(s) will result in development and implementation of a Plan of Action, and a repeat of the indicator(s) within 1-2 months to verify effectiveness.</p> <p>Criteria 5: March 3, 2014</p> | | |

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

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OMB NO. 0938-0391

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| F 323 | Continued From page 14 Interview conducted with RN #3 on 02/19/14, at 3:30 PM, revealed she had worked the 7:00 PM to 7:00 AM shift on 02/11/14. RN #3 stated Resident #6 was in bed when she went to the resident's room to check his/her blood glucose level at approximately 8:45 PM on 02/11/14. RN #3 stated after she obtained the results of the resident's blood glucose, she proceeded to administer insulin to the resident. The resident placed his/her left hand on the neck of his/her gown and pulled the gown down below the right breast area. The RN stated she observed edema and "a hard knot" on the resident's right shoulder and right breast area with dark purplish/red discoloration noted primarily to the resident's right amput. RN #3 stated although the resident was able to verbalize pain at times, the resident "mumbled" and did not verbalize he/she was in pain when asked if his/her right arm hurt. The RN stated she did not know what had caused the discoloration of the resident's right shoulder and breast and had not attempted to raise the resident's arm to assess further due to not knowing the extent of the injury. RN #3 stated she notified the resident's attending physician and arranged for the resident to be transferred to the ED. RN #3 further stated she received a call from the ED physician on 02/11/14 at approximately 11:00 PM, and the ED physician wanted to know what had caused the swelling and bruising to the resident's right shoulder. According to RN #3, she told the ED physician she did not know and the ED physician stated he was admitting the resident to the hospital for observation. Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/20/14, at 9:05 AM, | F 323 | | | |

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

PRINTED: 03/21/2014
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| F 323 | <p>Continued From page 15</p> <p>revealed she provided orientation to new employees and also observed employees on an annual basis perform competency skills to evaluate their ability to provide resident care. LPN #2 stated transfer procedures, following the care plan, and mechanical lift procedures were included in the training and annual competency skills checks. LPN #2 also stated she conducted "spot checks" daily to verify staff transferred residents according to their individual plan of care and she had not identified any problems.</p> <p>Review of the Annual Competency Check List completed on 01/15/14 for CNA #1, and for CNA #2 on 10/22/13, revealed the facility had assessed the CNAs to be competent in the use of the mechanical lift.</p> <p>Interview conducted with Physician #1 on 02/19/14, at 1:40 PM, revealed he was Resident #6's attending physician and had been contacted by the ED physician on 02/11/14 regarding Resident #6's injury. Physician #1 stated the ED physician said he did not know what had caused the resident's injury. Physician #1 stated he assessed Resident #6 on 02/12/14 and determined the injury was due to a torn pectoral muscle, and called the facility's Administrator to report the injury. He further stated the torn pectoral muscle most likely occurred when staff lifted Resident #6. Physician #1 stated the injury could have been prevented if the resident had been transferred with a mechanical lift.</p> <p>Interview conducted with the Administrator on 02/20/14, at 4:10 PM, revealed Physician #1 informed him the injury sustained by Resident #6 on 02/12/14 was due to a torn pectoral muscle. The Administrator stated a facility investigation</p> | F 323 | | | |

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

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| F 323 | <p>Continued From page 16</p> <p>was initiated and determined CNAs #1 and #2 failed to transfer Resident #6 using a mechanical lift on 02/11/14. The Administrator stated CNA #1 and CNA #2 had been suspended immediately and remained on suspension pending further investigation.</p> <p>2. Observations conducted on 02/18/14 at 1:00 PM revealed the hot water temperature in the women's shower room located on Station II was 132 degrees Fahrenheit (F) (22 degrees higher than the acceptable temperature range of 110 degrees Fahrenheit); the hot water temperature in the men's shower room located on Station II was observed to be 120 degrees F, and the hot water temperature in resident room 221 was observed to be 122 degrees F. Additional observations of the women and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature fluctuated from 90 degrees to 117 degrees F (10 degrees below and 17 degrees higher than the acceptable range).</p> <p>Review of the facility's census report on 02/18/14 revealed 18 residents resided on the two hallways located at Station II and had access to the shower rooms.</p> <p>Review of the Monthly Preventative Maintenance Checklist completed in December 2013, January 2014, and through February 18, 2014 revealed the hot water temperatures had been within normal limits.</p> <p>Interview conducted with the Maintenance Director on 02/18/14 at 1:30 PM (EST) revealed the hot water temperatures in the facility were</p> | F 323 | | | |

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

PRINTED: 03/21/2014
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| F 323 | <p>Continued From page 17</p> <p>maintained at 100-110 degrees F. According to the Maintenance Director, he had obtained the hot water temperatures located in resident rooms (rooms 106, 216, and 114) on Stations I and II on the morning of 02/18/14 and had not identified any concerns. Further interview with the Maintenance Director revealed the mixing valve on the hot water heater might have failed since he had obtained the temperatures, and he had shut the hot water to the Station II hallway off until the repairs could be completed. The Maintenance Director stated he had ordered the defective part for the mixing valve on 02/18/14 and expected it to be delivered to the facility on 02/21/14. The Maintenance Director also stated he had directed staff to use the shower rooms on Station I for bathing residents until the repairs were made.</p> <p>An interview conducted with the Administrator on 02/20/14 at 3:47 PM revealed he had not received any complaints about water temperatures. The Administrator stated he had not been aware of any concerns with the hot water temperatures or the failure of the mixing valves until the Maintenance Director had informed him on 02/20/14.</p> | F 323 | | | |



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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | STREET ADDRESS, CITY, STATE ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 Division of Health Care Southern Enforcement Branch | | | |
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| N 000 | INITIAL COMMENTS A relicensure survey was conducted on 02/17-20/14. Deficient practice was identified. | N 000 | Plan of Correction Cumberland Valley Manor Standard Survey 2/20/14 | | |
| N 137 | 902 KAR 20:300-6(7)(a)5. Section 6. Quality Of Life (7) Environment (a) The facility shall provide: 5. Adequate and comfortable lighting levels in all areas; comfortable and safe temperature levels. This requirement is not met as evidenced by: Based on observation, interviews, and review of the facility's policy, Room Temperature Levels, it was determined the facility failed to ensure temperature levels were maintained between 71 and 81 degrees Fahrenheit in the Station III Dining Room in order to provide comfortable and safe air temperatures levels for eight (8) of eight (8) unsampled residents. Observation of the breakfast meal on 02/18/14 revealed eight (8) unsampled residents were eating in the Station III Dining Room. The air temperature in the Station III Dining Room was obtained and was noted to be 67 degrees Fahrenheit. The findings include: Review of the facility's policy titled Room Temperature Levels (undated) revealed it was the facility's policy to maintain an optimal room temperature range of 71 to 81 degrees Fahrenheit (F). Observation of the room air temperature in the Station III Dining Room was taken on 02/18/14 at 8:24 AM and revealed the temperature, during the morning meal, was 67 degrees F. Further | N 137 | Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. N 137 902 KAR 20:300-6(7)(a)5. Section 6. Quality of Life. (7) Environment.(a) The facility shall provide: 5. Adequate and comfortable lighting levels in all areas; comfortable and safe temperature levels. Criteria 1: The thermostat in Dining Room #3 was adjusted to between 71 - 81°F, and a lock out box was placed over the thermostat in the classroom to determine that only designated staff can adjust the temperature. | | |

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

Paul Sly

TITLE

Administrator

(X8) DATE

03/28/14

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 | | |
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| N 137 | <p>Continued From page 1</p> <p>observations revealed three of the eight residents seated in the Dining Room were covered with blankets.</p> <p>A group interview was conducted on 02/18/14 at 11:30 AM with six alert and oriented residents. During the interview, three of the residents complained that the Station III Dining Room was often "cold" during meals.</p> <p>An interview on 02/20/14 at 4:56 PM, with the Infection Control Nurse revealed she occupied the office next to the Station III Dining Room. According to the Infection Control Nurse, she was aware the thermostat in the office could affect the temperature of the Dining Room. She further stated her office was too hot at times and she would adjust the thermostat. The Infection Control Nurse was not aware of the required air temperature range in the facility.</p> <p>Interview conducted with the Maintenance Director on 02/20/14 at 1:30 PM revealed the Maintenance Department staff monitored room temperatures on a daily basis and adjustments were made if necessary. According to the Maintenance Director, he was not aware the Dining Room temperature was 67 degrees Fahrenheit on 02/18/14, and had not been maintained between 71 and 81 degrees F. Further interview with the Maintenance Director revealed there was a thermostat located in the Dining Room and a thermostat located in a classroom adjacent to the Station III Dining Room. The Maintenance Director stated if staff adjusted the thermostat in the classroom, it could affect the temperature in the Dining Room. The Maintenance Director stated even though the room temperatures were monitored on a daily basis, he did not maintain a log of the room</p> | N 137 | <p>Criteria 2: All thermostats in common areas of the facility were inspected by the Maintenance Director/Administrator on 02/21/14 to determine that the temperature in all common areas was maintained between 71 - 81°F. All areas were in compliance with these temperatures.</p> <p>Criteria 3: The maintenance staff were provided in-service education by the Administrator on 02/21/14, on the need to monitor the thermostats in resident common areas weekly to determine that temperatures are maintained between 71 - 81°F, and are documenting all temperatures that fall outside of the these required parameters. Any discrepancies are to be brought to the attention of the administrator via verbal report, and addressed as indicated.</p> <p>Criteria 4: The CQI indicator for the monitoring of facility temperatures maintained in the range of 71-81°F will be utilized monthly X 2 months then quarterly as per the CQI calendar under the supervision of the Environmental Supervisor.. Failure to achieve the required indicator threshold will</p> | | |

Office of Inspector General

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| N 137 | Continued From page 2 temperatures, and was not aware of any resident concerns related to the air temperature. | N 137 | result in development and implementation of a Plan of Action, and a repeat of the indicator within 1-2 months to verify effectiveness. | |
| N 194 | <p>902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Care Plan Policy Statement, the Certified Nurse Aide (CNA) Care Plan Record policy, and the facility's investigation, it was determined the facility failed to ensure services were provided in accordance with the written plan of care for one (1) of seventeen (17) sampled residents. (Resident #6). The facility assessed Resident #6 to require staff support with transfers and had care plan interventions for a mechanical lift to be used during all transfers. However, facility staff failed to utilize a mechanical lift during a transfer on 02/11/14 at approximately 7:00 PM. On 02/11/14 at approximately 9:00 PM, staff assessed the resident to have bruising and swelling of the right arm/shoulder. The facility transferred the resident to the Emergency Department (ED) for evaluation and treatment. Review of the Emergency Department's Physician's Progress Notes revealed the resident was diagnosed with a torn right pectoral muscle.</p> <p>The findings include:</p> | N 194 | <p>Criteria 5: March 3, 2014</p> <p>N 194 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment The services provided or arranged by The facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Criteria 1:-The MD and RP for Resident #6 were notified of the bruising/injury identified during assessment. Resident #6 was transferred to the Emergency Room for further assessment and treatment. -Observations of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for resident #6 as follows: with each transfer for 24 hours, then done randomly with a transfer once per shift for 3 days, then done randomly with a transfer once per day for 3 days, as performed by the charge nurses and/or administrative nurses.</p> | |

Office of Inspector General

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| N 194 | <p>Continued From page 3</p> <p>Review of the facility's Care Plan Policy Statement (not dated) revealed a Comprehensive Plan of Care would be developed by the interdisciplinary team based on the completion of the comprehensive Minimum Data Set (MDS) assessment. The policy statement did not address implementation of the residents' care plans.</p> <p>Review of the Certified Nurse Aide (CNA) Care Plan Record policy (no date) revealed the care plan would be utilized to identify/document each resident's daily care needs. The policy further noted the CNA care plan would provide information regarding the amount of assistance the resident required for transfers and any assistive devices to be used for mobility.</p> <p>Review of the Quarterly MDS assessment dated 12/19/13, revealed the facility assessed Resident #6 to require total assistance of two staff persons for transfers. The MDS further revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan with a review date of 12/20/13, revealed the facility had addressed the resident's alteration in mobility. Interventions included using a mechanical lift for all transfers. Review of the CNA care plan dated February 2014 revealed Resident #6 was non-weight bearing and staff was directed to use a "Viking" lift (a mobile device used for lifting) for transfers.</p> <p>Review of the February 2014 physician's orders revealed staff was to transfer Resident #6 with the use of a mechanical lift.</p> | N 194 | <p>-Daily skin assessments will be performed for resident #6 by the charge nurses for 7 days, then weekly thereafter to monitor the status of the bruising/injury. The MD will be notified of any changes in healing status.</p> <p>-Disciplinary action was implemented per facility policy for the identified staff who failed to utilize the mechanical lift in accordance with the care plan.</p> <p>Criteria 2: -Head to toe skin assessments were completed by the administrative and charge nurse staff for all residents to identify any changes in skin status, or unidentified bruises that had not yet been addressed. No areas were identified that had not been addressed.</p> <p>-The care plans and C.N.A care plans for all residents assessed to require mechanical lift use, were reviewed to determine that this intervention was addressed as indicated.</p> <p>-Observation of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for all residents requiring this intervention by the charge nurses and/or administrative</p> | |

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| N 194 | <p>Continued From page 4</p> <p>Review of the facility's investigation, dated 02/12/14 at 9:00 AM, revealed facility staff failed to utilize a mechanical lift during transfer of Resident #6 from the chair to the bed on 02/11/14 at approximately 7:00 PM. Continued review of the investigation revealed on 02/11/14 at approximately 9:00 PM, after staff transferred the resident to bed, Registered Nurse (RN) #3 assessed Resident #6 and noted the resident had a newly identified discolored area and edema of the right shoulder area. Further review revealed the facility transferred the resident to the Emergency Department (ED) for further evaluation and treatment. According to the Emergency Department's Physician's Report, the resident had a large amount of "ecchymosis" (escape of blood into the tissues from ruptured blood vessels, marked by a purple discoloration of the skin) and a firm/swollen area on the right shoulder. Further review of the ED Report revealed no fractures were identified and the resident was diagnosed with a right torn pectoral muscle "probably associated with moving or pulling the patient up in bed or the wheelchair."</p> <p>Observation of a skin assessment conducted by facility staff on 02/18/14, at 11:10 AM, revealed Resident #6 had a raised area measuring 13 centimeters (cm) by 10 cm on the anterior area of the right shoulder; fading dark purple bruising measuring 3.5 cm by 9 cm near the right axilla; a 22 cm by 10.5 cm yellowish fading discoloration across the resident's upper chest area; a 16 cm yellow fading area extending down the resident's right upper arm; and a 16 cm by 10 cm yellow/purplish area on the right side under the resident's rib cage.</p> <p>Observation at 12:10 PM on 02/18/14, revealed</p> | N 194 | <p>nurses randomly once per day for 3 days.</p> <p>-Compliance rounds are conducted weekly by the Administrative/Charge Nurse staff to monitor nursing staff compliance with the care plan interventions.</p> <p><u>Criteria 3: -In-service education was provided for the nursing staff by the DON/ADON/Restorative Coordinator on the following:</u></p> <p>-Correct and consistent use of the mechanical lift in accordance with the resident care plan.</p> <p>-<u>Provision of all resident care in accordance with the care plan, with notification of the charge nurse if the nursing assistants should identify any obstacle that would prevent them from being able to comply with the care plan.</u></p> <p>-Safe transfer technique for residents who do not require use of a mechanical lift.</p> <p>-Immediate reporting of any identified changes in skin status, including bruising, to the charge nurse by the nursing assistants, and to the MD and RP by the charge nurses.</p> <p>-Licensed nurses were provided in-service education by the DON/ADON/Wound Nurse on the</p> | |
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Office of Inspector General

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| N 194 | <p>Continued From page 5</p> <p>CNAs #7 and #10 transferred Resident #6 from the bed into a Broda chair (chair that reduces pressure and provides long-term sitting support) using the mechanical lift device.</p> <p>Interview conducted with CNA #1 on 02/18/14, at 3:55 PM, revealed he had been trained to review the CNA care plan at the beginning of each shift. However, the CNA stated he had not looked at the care plan "in a while" and did not know Resident #6 was to be transferred using a mechanical lift. CNA #1 stated he and CNA #2 transferred Resident #6 from the Broda chair to the bed at approximately 7:00 PM on 02/11/14. CNA #1 stated he and CNA #2 each placed an arm underneath the resident's arms and their hand on the resident's waist and assisted the resident onto the bed. CNA #1 stated during the transfer on 02/11/14, he observed a fading bruise on the resident's right upper arm that had been caused by the application of a blood pressure cuff from "about" a week earlier. The CNA stated he did not observe any new bruises at the time of the transfer. CNA #1 also stated the resident did not exhibit or verbalize pain during or after the transfer.</p> <p>Interview conducted with CNA #2 on 02/18/14, at 4:15 PM, revealed she also had been trained to follow the CNA care plan when she transferred a resident. CNA #2 stated she knew Resident #6 was to be transferred at all times with a mechanical lift. She stated that she assisted CNA #1 to transfer Resident #6 from the Broda chair to the bed on 02/11/14, at approximately 7:00 PM. CNA #2 stated Resident #6 was transferred using a two-person transfer and the mechanical lift had not been used. She further stated she did not tell CNA #1 the resident was supposed to be transferred with the mechanical lift and she did</p> | N 194 | <p>completion and documentation of thorough skin assessments, with measurements of any identified bruising for monitoring purposes. Any changes in skin status or declines in the healing status of bruises are to be reported to the physician.</p> <p>Criteria 4: -A CQI Meeting with the Medical Director and CQI team was held on 2-13-14 to review the facility investigation and the Plan of Correction</p> <p>-The CQI indicator for the monitoring of provision of resident care in accordance with the care plan (such as use of lifts, type and number of staff assistance, use of devices, dietary restrictions etc.) will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. Failure to achieve the established threshold will result in development and implementation of a Plan of Action, and a repeat of the indicator within 1-2 months to verify effectiveness.</p> <p>Criteria 5: March 3, 2014</p> | |

Office of Inspector General

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| N 194 | <p>Continued From page 6</p> <p>not know why the lift had not been used.</p> <p>Interview conducted with the Director of Nursing (DON) on 02/19/14 at 11:50 AM, revealed the Charge Nurse was responsible to monitor care being provided by the CNAs and to ensure the care was in accordance with the resident's plan of care. The DON stated RN #3 called her at home after discovering the bruises on the resident's right shoulder area when the nurse was preparing to administer an injection to the resident on 02/11/14. The DON stated the nurse reported the resident did not complain of pain, but the bruising was discovered after the resident pulled his/her gown down below his/her right shoulder and breast area.</p> <p>Interview conducted on 02/19/14, at 1:50 PM with RN #2 revealed she was the Charge Nurse for Station I, the unit where Resident #6 resided. She stated her responsibilities included monitoring resident care. RN #2 stated she periodically reminded the CNAs to read the residents' CNA care plans to ensure they knew what care needs the resident required. RN #2 stated she also observed staff providing resident care when she often walked by resident rooms. The RN stated she had observed staff transferring residents, but had not had the opportunity to observe the CNAs transfer Resident #6.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/20/14, at 9:05 AM, revealed she was responsible for orientation with new employees and competency skills checks annually to evaluate staff's ability to provide resident care. LPN #2 stated transfer procedures, following the care plan, and mechanical lift procedures were included in the</p> | N 194 | | |

Office of Inspector General

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| N 194 | Continued From page 7 training and annual competency skills checks. LPN #2 also stated she conducted "spot checks" daily to verify residents were being transferred according to their individual plan of care and she had not identified any problems. Interview with the facility's Compliance Officer on 02/20/14, at 4:00 PM, revealed the facility did not have a specific policy/procedure related to implementation of the resident's written plan of care. The Compliance Officer stated random audits were conducted by the administrative nurses to monitor direct care staff to ensure care needs were provided according to the resident's individual care plan. The Compliance Officer stated no problems had been reported concerning resident transfers prior to the incident involving Resident #6. | N 194 | | |
| N 219 | 902 KAR 20:300-8(7)(a) Section 8. Quality of Care (7) Accidents. The facility shall ensure that (a) The resident environment remains as free of accident hazards as is possible; and This requirement is not met as evidenced by: Based on observation, interviews, record reviews, and review of the facility's policies, Investigation Report, and the Emergency Department (ED) Record and the Physician's Progress Notes, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents was provided for one (1) of seventeen (17) sampled residents (Resident #6). Review of the Comprehensive Care Plan and the | N 219 | N 219 902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (a) The resident environment remains as free of accident hazards as is possible, and. Criteria 1: -The MD and RP for Resident #6 were notified of the bruising/injury identified during assessment. Resident #6 was transferred to the Emergency Room for further assessment and treatment. | |

Office of Inspector General

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| N 219 | <p>Continued From page 8</p> <p>Certified Nurse Aide (CNA) Care Plan revealed the facility assessed Resident #6 to require the total assistance of two staff persons and the use of a mechanical lift for all transfers. However, facility staff failed to transfer Resident #6 from the chair to the bed with the assistance of a mechanical lift on 02/11/14 at approximately 7:00 PM. On 02/11/14, at approximately 9:00 PM, after staff had transferred the resident from the chair to the bed, a nurse entered the resident's room to monitor the resident's blood glucose level. At that time, the resident reached over with his/her left hand and pulled the gown down from his/her right shoulder. The nurse observed the resident's right shoulder was swollen and bruised. The facility transferred Resident #6 to the Emergency Department (ED) for further evaluation and treatment, and according to the ED Physician's Progress Note dated 02/11/14, Resident #6 had sustained a torn pectoral muscle of the right shoulder area.</p> <p>In addition, observations on 02/18/14 at 1:00 PM revealed the hot water temperatures in the women's shower room on Station II was 132 degrees Fahrenheit (F) (22 degrees above the acceptable temperature range); the hot water temperature in the men's shower room on Station II was 120 degrees Fahrenheit (10 degrees above acceptable temperature range); and the hot water temperature in resident room 221 was observed to be 122 degrees F (12 degrees above the acceptable temperature range). Additional observations of the women's and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature in the areas fluctuated from 90 degrees to 117 degrees F. Further observation on 02/18/14 at 1:30 PM, revealed the hot water temperature at the mixing</p> | N 219 | <p>-Observations of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for resident #6 as follows: with each transfer for 24 hours, then done randomly with a transfer once per shift for 3 days, then done randomly with a transfer once per day for 3 days, as performed by the charge nurses and/or administrative nurses..</p> <p>-Daily skin assessments will be performed for resident #6 by the charge nurses for 7 days, then weekly thereafter to monitor the status of the bruising/injury. The MD will be notified of any changes in healing status.</p> <p>-Disciplinary action was implemented per facility policy for the identified staff who failed to utilize the mechanical lift in accordance with the care plan.</p> <p>-The temperature on the water heaters servicing Hall 2 was immediately turned down upon identification of the elevated levels. The necessary part was ordered and replaced by maintenance on 02/21/14.</p> | |

Office of Inspector General

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| N 219 | <p>Continued From page 9</p> <p>valve for the Station II hallway was 120 degrees (10 degrees above the acceptable temperature range).</p> <p>The findings include:</p> <p>Review of the Mechanical Lift policy (no date) revealed a safe working environment would be provided by utilizing a lift transfer system as deemed appropriate based on the resident's comprehensive assessment and the resident care planning process. The policy noted facility staff was required to use the mechanical lift equipment when specified by the resident assessment and care plan.</p> <p>An interview with the Administrator on 02/20/14 at 3:47 PM revealed the facility did not have a written policy that directed staff how and/or when to monitor water temperatures. However, according to the Administrator, it was the facility's procedure for the Maintenance Department to check the water temperatures on a daily basis in resident care areas and to document the temperature on the preventive maintenance checklist for each month. The Administrator stated the facility's Maintenance Department attempted to maintain the water temperatures between 100 and 110 degrees Fahrenheit (F).</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 10/05/10 with diagnoses including Alzheimer's disease, Arthropathy, Vertigo, Reactive Confusion, and Coronary Artery Disease with graft. Review of the Quarterly Comprehensive Assessment dated 12/19/13, revealed the facility assessed Resident #6 to require total assistance of two staff members for transfers and a wheelchair was used for mobility/locomotion. The MDS further</p> | N 219 | <p>Criteria 2: -Head to toe skin assessments were completed by the administrative and charge nurse staff for all residents to identify any changes in skin status, or unidentified bruises that had not yet been addressed. No areas were identified that had not been addressed.</p> <p>-The care plans and C.N.A care plans for all residents assessed to require mechanical lift use, were reviewed to determine that this intervention was addressed as indicated.</p> <p>-Observation of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for all residents requiring this intervention by the charge nurses and/or administrative nurses randomly once per day for 3 days.</p> <p>-Water temperatures were tested throughout the facility, with all other temperatures determined to be within the required parameters.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility and to develop and implement a Plan of Action for any identified issues. The Safety Committee</p> | |

Office of Inspector General

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| N 219 | <p>Continued From page 10</p> <p>revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan reviewed/updated on 12/20/13, revealed the facility addressed the resident's alteration in mobility related to a history of falls and diagnoses of Alzheimer's and Reactive Confusion. Interventions included instructing the resident on appropriate use of assistive/supportive devices; to verbally remind the resident not to ambulate or transfer without assistance; and to use a mechanical lift for all transfers. Further record review revealed the February 2014 CNA care plan indicated the resident was non-weight bearing and required the use of a "Viking" lift (a mobile device used for lifting) for transfers.</p> <p>Review of the facility's Investigation Report dated 02/12/14, at 9:00 AM, revealed after the ED physician contacted the resident's attending physician regarding the resident's injury, the resident's attending physician contacted the facility to inform the Administrator of the injury to Resident #6's shoulder. The facility initiated an investigation on 02/12/14 and interviewed all staff who had provided care for Resident #6 from 02/06-11/14. Based on the findings of the facility's investigation, the facility determined Certified Nurse Aide (CNA) #1 and CNA #2 had transferred Resident #6 from a Broda chair (chair that reduces pressure and provides long-term sitting support) to the bed on 02/11/14 at approximately 7:00 PM. However, according to the facility's investigation, CNAs #1 and #2 failed to follow the Plan of Care that had been developed for Resident #6 as they failed to use a mechanical lift when they transferred the resident</p> | N 219 | <p>findings are presented to the QA Committee for review.</p> <p>Criteria 3: -In-service education was provided for the nursing staff by the DON/ADON/Restorative Coordinator on the following: -Correct and consistent use of the mechanical lift in accordance with the resident care plan. -Provision of all resident care in accordance with the care plan, with notification of the charge nurse if the nursing assistants should identify any obstacle that would prevent them from being able to comply with the care plan. -Safe transfer technique for residents who do not require use of a mechanical lift. -Immediate reporting of any identified changes in skin status, including bruising, to the charge nurse by the nursing assistants, and to the MD and RP by the charge nurses. -Licensed nurses were provided in-service education by the DON/ADON/Wound Nurse on the completion and documentation of thorough skin assessments, with measurements of any identified bruising for monitoring purposes.</p> | |

Office of Inspector General

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| N 219 | <p>Continued From page 11</p> <p>to bed. The investigation further revealed when Registered Nurse (RN) #3 entered Resident #6's room on 02/11/14 at approximately 9:00 PM to monitor the resident's blood glucose levels, the resident pulled his/her gown down from the right shoulder area with his/her left hand. The nurse observed "new" bruising and swelling to the resident's right shoulder area.</p> <p>Observation of a skin assessment conducted by facility staff on 02/18/14, at 11:10 AM, revealed Resident #6 had a raised area measuring 13 centimeters (cm) by 10 cm on the anterior area of the right shoulder; fading dark purple bruising measuring 3.5 cm by 9 cm near the right axilla; a 22 cm by 10.5 cm yellowish fading discoloration across the resident's upper chest area; a 16 cm yellow fading discolored area extending down the resident's right upper arm; and a 16 cm by 10 cm yellow/purplish area on the right side under the resident's rib cage.</p> <p>Review of documentation by nursing staff in Resident #6's medical record dated 02/11/14, at 9:04 PM, revealed RN #3 entered the resident's room to assess the resident's blood glucose level and noted the resident had discoloration and edema of the right shoulder. Further review revealed RN #3 notified the physician and arranged for the resident to be transferred to the hospital's ED for further evaluation and treatment.</p> <p>Review of the ED record dated 02/11/14, revealed Resident #6 was assessed to have a large amount of ecchymosis (bruising) and a "firm/swollen" area of the right shoulder. X-rays obtained at the ED revealed no evidence of a fracture or dislocation of the right shoulder. Further review of the ED report revealed the resident was admitted to the hospital on 02/11/14</p> | N 219 | <p>Any changes in skin status or declines in the healing status of bruises are to be reported to the physician.</p> <p>-The maintenance staff have received in-service education by the administrator on 02/21/14 regarding the need to inspect the water heater units monthly to determine they are maintaining water temperatures within the required parameters, and to test water temperatures randomly throughout the facility in accordance with the preventive maintenance logs.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility and to develop and implement a Plan of Action for any identified issues. The Safety Committee findings are presented to the QA Committee for review.</p> <p>Criteria 4: -A CQI Meeting with the Medical Director and CQI team was held on 2-13-14 to review the facility investigation and the Plan of Correction</p> <p>-The CQI indicator for the monitoring of provision of resident care in accordance with the care plan (such as use of lifts, type and</p> | |

Office of Inspector General

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| N 219 | <p>Continued From page 12 for observation.</p> <p>Review of Resident #6's Attending Physician's Progress Note, dated 02/11/14, revealed the physician assessed Resident #6 to have a hematoma (bruising) to the right anterior chest with bruising to the right upper arm. Further review of the Physician's Progress Note revealed the cause of the bruising "appeared to be a torn muscle/tendon." The physician further noted the tear was probably associated with moving or pulling the resident up in bed or a wheelchair.</p> <p>Interview conducted with CNA #1 on 02/18/14, at 3:55 PM, revealed staff should review the CNA care plan each shift to determine the care needs of each resident. According to CNA #1, the CNA care plan included the requirements staff was to follow for each resident's transfer. CNA #1 stated he had not looked at Resident #6's care plan "in a while" and did not know a mechanical lift was to be used for transfers for Resident #6. CNA #1 stated he and CNA #2 transferred Resident #6 from the Broda chair to the bed at approximately 7:00 PM on 02/11/14. CNA #1 stated he and CNA #2 had placed one arm underneath the resident's arms and placed a hand on the resident's waistband, and assisted the resident to transfer from the chair to the bed. CNA #1 confirmed he did not see any bruises or swelling on the resident's right shoulder area. CNA #1 further stated the resident did not indicate any injury or pain had occurred during the transfer.</p> <p>Interview conducted with CNA #2 on 02/18/14, at 4:15 PM, revealed she was aware Resident #6 was to be transferred at all times with a mechanical lift. CNA #2 stated she assisted CNA #1 to transfer Resident #6 from the Broda chair to the bed on 02/11/14, at approximately 7:00 PM</p> | N 219 | <p>number of staff assistance, use of devices, dietary restrictions etc.) will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>-The CQI indicator for the monitoring of facility water temperatures within the required range of 100-110°F will be utilized monthly X 2 months, and then every six months as per the established CQI calendar under the supervision of the Maintenance Director. Water temperatures will also be checked and documented daily by maintenance or designated staff.</p> <p>- Failure to achieve the established threshold for the CQI indicator(s) will result in development and implementation of a Plan of Action, and a repeat of the indicator(s) within 1-2 months to verify effectiveness.</p> <p>Criteria 5: March 3, 2014</p> | |

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| N 219 | <p>Continued From page 13</p> <p>and a mechanical lift had not been used during the transfer. CNA #2 stated she did not tell CNA #1 staff was to use a mechanical lift when they transferred Resident #6 and offered no explanation as to why they had not used the mechanical lift.</p> <p>Interview conducted with RN #3 on 02/19/14, at 3:30 PM, revealed she had worked the 7:00 PM to 7:00 AM shift on 02/11/14. RN #3 stated Resident #6 was in bed when she went to the resident's room to check his/her blood glucose level at approximately 8:45 PM on 02/11/14. RN #3 stated after she obtained the results of the resident's blood glucose, she proceeded to administer insulin to the resident. The resident placed his/her left hand on the neck of his/her gown and pulled the gown down below the right breast area. The RN stated she observed edema and "a hard knot" on the resident's right shoulder and right breast area with dark purplish/red discoloration noted primarily to the resident's right armpit. RN #3 stated although the resident was able to verbalize pain at times, the resident "mumbled" and did not verbalize he/she was in pain when asked if his/her right arm hurt. The RN stated she did not know what had caused the discoloration of the resident's right shoulder and breast and had not attempted to raise the resident's arm to assess further due to not knowing the extent of the injury. RN #3 stated she notified the resident's attending physician and arranged for the resident to be transferred to the ED. RN #3 further stated she received a call from the ED physician on 02/11/14 at approximately 11:00 PM, and the ED physician wanted to know what had caused the swelling and bruising to the resident's right shoulder. According to RN #3, she told the ED physician she did not know and the ED physician stated he</p> | N 219 | | |

Office of Inspector General

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| N 219 | <p>Continued From page 14</p> <p>was admitting the resident to the hospital for observation.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/20/14, at 9:05 AM, revealed she provided orientation to new employees and also observed employees on an annual basis perform competency skills to evaluate their ability to provide resident care. LPN #2 stated transfer procedures, following the care plan, and mechanical lift procedures were included in the training and annual competency skills checks. LPN #2 also stated she conducted "spot checks" daily to verify staff transferred residents according to their individual plan of care and she had not identified any problems.</p> <p>Review of the Annual Competency Check List completed on 01/15/14 for CNA #1, and for CNA #2 on 10/22/13, revealed the facility had assessed the CNAs to be competent in the use of the mechanical lift.</p> <p>Interview conducted with Physician #1 on 02/19/14, at 1:40 PM, revealed he was Resident #6's attending physician and had been contacted by the ED physician on 02/11/14 regarding Resident #6's injury. Physician #1 stated the ED physician said he did not know what had caused the resident's injury. Physician #1 stated he assessed Resident #6 on 02/12/14 and determined the injury was due to a torn pectoral muscle, and called the facility's Administrator to report the injury. He further stated the torn pectoral muscle most likely occurred when staff lifted Resident #6. Physician #1 stated the injury could have been prevented if the resident had been transferred with a mechanical lift.</p> <p>Interview conducted with the Administrator on</p> | N 219 | | |

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| N 219 | <p>Continued From page 15</p> <p>02/20/14, at 4:10 PM, revealed Physician #1 informed him the injury sustained by Resident #6 on 02/12/14 was due to a torn pectoral muscle. The Administrator stated a facility investigation was initiated and determined CNAs #1 and #2 failed to transfer Resident #6 using a mechanical lift on 02/11/14. The Administrator stated CNA #1 and CNA #2 had been suspended immediately and remained on suspension pending further investigation.</p> <p>2. Observations conducted on 02/18/14 at 1:00 PM revealed the hot water temperature in the women's shower room located on Station II was 132 degrees Fahrenheit (F) (22 degrees higher than the acceptable temperature range of 110 degrees Fahrenheit); the hot water temperature in the men's shower room located on Station II was observed to be 120 degrees F; and the hot water temperature in resident room 221 was observed to be 122 degrees F. Additional observations of the women and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature fluctuated from 90 degrees to 117 degrees F (10 degrees below and 17 degrees higher than the acceptable range).</p> <p>Review of the facility's census report on 02/18/14 revealed 18 residents resided on the two hallways located at Station II and had access to the shower rooms.</p> <p>Review of the Monthly Preventative Maintenance Checklist completed in December 2013, January 2014, and through February 18, 2014 revealed the hot water temperatures had been within normal limits.</p> | N 219 | | |

Office of Inspector General

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| N 219 | Continued From page 16 Interview conducted with the Maintenance Director on 02/18/14 at 1:30 PM (EST) revealed the hot water temperatures in the facility were maintained at 100-110 degrees F. According to the Maintenance Director, he had obtained the hot water temperatures located in resident rooms (rooms 106, 216, and 114) on Stations I and II on the morning of 02/18/14 and had not identified any concerns. Further interview with the Maintenance Director revealed the mixing valve on the hot water heater might have failed since he had obtained the temperatures, and he had shut the hot water to the Station II hallway off until the repairs could be completed. The Maintenance Director stated he had ordered the defective part for the mixing valve on 02/18/14 and expected it to be delivered to the facility on 02/21/14. The Maintenance Director also stated he had directed staff to use the shower rooms on Station I for bathing residents until the repairs were made. An interview conducted with the Administrator on 02/20/14 at 3:47 PM revealed he had not received any complaints about water temperatures. The Administrator stated he had not been aware of any concerns with the hot water temperatures or the failure of the mixing valves until the Maintenance Director had informed him on 02/20/14. | N 219 | | |
| N 220 | 902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that (b) Each resident receives adequate supervision and assistive devices to prevent accidents. | N 220 | N 220 902 KAR 20:300-8(7)(b) Section 8. Quality of Care The facility must ensure that the resident environment remains as free of accident hazards as is possible. | |

Office of Inspector General

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| N 220 | <p>Continued From page 17</p> <p>This requirement is not met as evidenced by: Based on observation, interviews, record reviews, and review of the facility's policies, Investigation Report, and the Emergency Department (ED) Record and the Physician's Progress Notes, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents was provided for one (1) of seventeen (17) sampled residents (Resident #6).</p> <p>Review of the Comprehensive Care Plan and the Certified Nurse Aide (CNA) Care Plan revealed the facility assessed Resident #6 to require the total assistance of two staff persons and the use of a mechanical lift for all transfers. However, facility staff failed to transfer Resident #6 from the chair to the bed with the assistance of a mechanical lift on 02/11/14 at approximately 7:00 PM. On 02/11/14, at approximately 9:00 PM, after staff had transferred the resident from the chair to the bed, a nurse entered the resident's room to monitor the resident's blood glucose level. At that time, the resident reached over with his/her left hand and pulled the gown down from his/her right shoulder. The nurse observed the resident's right shoulder was swollen and bruised. The facility transferred Resident #6 to the Emergency Department (ED) for further evaluation and treatment, and according to the ED Physician's Progress Note dated 02/11/14, Resident #6 had sustained a torn pectoral muscle of the right shoulder area.</p> <p>In addition, observations on 02/18/14 at 1:00 PM revealed the hot water temperatures in the women's shower room on Station II was 132</p> | N 220 | <p>Criteria 1: -The MD and RP for Resident #6 were notified of the bruising/injury identified during assessment. Resident #6 was transferred to the Emergency Room for further assessment and treatment.</p> <p>-Observations of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for resident #6 as follows: with each transfer for 24 hours, then done randomly with a transfer once per shift for 3 days, then done randomly with a transfer once per day for 3 days, as performed by the charge nurses and/or administrative nurses.</p> <p>-Daily skin assessments will be performed for resident #6 by the charge nurses for 7 days, then weekly thereafter to monitor the status of the bruising/injury. The MD will be notified of any changes in healing status.</p> <p>-Disciplinary action was implemented per facility policy for the identified staff who failed to utilize the mechanical lift in accordance with the care plan.</p> <p>-The temperature on the water heaters servicing Hall 2 was immediately turned down upon identification of the elevated levels.</p> | |

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| N 220 | <p>Continued From page 18</p> <p>degrees Fahrenheit (F) (22 degrees above the acceptable temperature range); the hot water temperature in the men's shower room on Station II was 120 degrees Fahrenheit (10 degrees above acceptable temperature range); and the hot water temperature in resident room 221 was observed to be 122 degrees F (12 degrees above the acceptable temperature range). Additional observations of the women's and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature in the areas fluctuated from 90 degrees to 117 degrees F. Further observation on 02/18/14 at 1:30 PM, revealed the hot water temperature at the mixing valve for the Station II hallway was 120 degrees (10 degrees above the acceptable temperature range).</p> <p>The findings include:</p> <p>Review of the Mechanical Lift policy (no date) revealed a safe working environment would be provided by utilizing a lift transfer system as deemed appropriate based on the resident's comprehensive assessment and the resident care planning process. The policy noted facility staff was required to use the mechanical lift equipment when specified by the resident assessment and care plan.</p> <p>An interview with the Administrator on 02/20/14 at 3:47 PM revealed the facility did not have a written policy that directed staff how and/or when to monitor water temperatures. However, according to the Administrator, it was the facility's procedure for the Maintenance Department to check the water temperatures on a daily basis in resident care areas and to document the temperature on the preventive maintenance</p> | N 220 | <p>The necessary part was ordered and replaced by maintenance on 02/21/14.</p> <p>Criteria 2: -Head to toe skin assessments were completed by the administrative and charge nurse staff for all residents to identify any changes in skin status, or unidentified bruises that had not yet been addressed. No areas were identified that had not been addressed.</p> <p>-The care plans and C.N.A care plans for all residents assessed to require mechanical lift use, were reviewed to determine that this intervention was addressed as indicated.</p> <p>-Observation of consistent and correct use of the mechanical lift in accordance with the care plan, will be performed for all residents requiring this intervention by the charge nurses and/or administrative nurses randomly once per day for 3 days.</p> <p>-Water temperatures were tested throughout the facility, with all other temperatures determined to be within the required parameters.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility</p> | |

Office of Inspector General

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| N 220 | <p>Continued From page 19</p> <p>checklist for each month. The Administrator stated the facility's Maintenance Department attempted to maintain the water temperatures between 100 and 110 degrees Fahrenheit (F).</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 10/05/10 with diagnoses including Alzheimer's disease, Arthropathy, Vertigo, Reactive Confusion, and Coronary Artery Disease with graft. Review of the Quarterly Comprehensive Assessment dated 12/19/13, revealed the facility assessed Resident #6 to require total assistance of two staff members for transfers and a wheelchair was used for mobility/locomotion. The MDS further revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan reviewed/updated on 12/20/13, revealed the facility addressed the resident's alteration in mobility related to a history of falls and diagnoses of Alzheimer's and Reactive Confusion. Interventions included instructing the resident on appropriate use of assistive/supportive devices; to verbally remind the resident not to ambulate or transfer without assistance; and to use a mechanical lift for all transfers. Further record review revealed the February 2014 CNA care plan indicated the resident was non-weight bearing and required the use of a "Viking" lift (a mobile device used for lifting) for transfers.</p> <p>Review of the facility's Investigation Report dated 02/12/14, at 9:00 AM, revealed after the ED physician contacted the resident's attending physician regarding the resident's injury, the resident's attending physician contacted the</p> | N 220 | <p>and to develop and implement a Plan of Action for any identified issues. The Safety Committee findings are presented to the QA Committee for review.</p> <p>Criteria 3: -In-service education was provided for the nursing staff by the DON/ADON/Restorative Coordinator on the following: -Correct and consistent use of the mechanical lift in accordance with the resident care plan. -Provision of all resident care in accordance with the care plan, with notification of the charge nurse if the nursing assistants should identify any obstacle that would prevent them from being able to comply with the care plan. -Safe transfer technique for residents who do not require use of a mechanical lift. -Immediate reporting of any identified changes in skin status, including bruising, to the charge nurse by the nursing assistants, and to the MD and RP by the charge nurses. -Licensed nurses were provided in-service education by the DON/ADON/Wound Nurse on the completion and documentation of</p> | | |

Office of Inspector General

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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 |
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| (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) COMPLETE DATE |
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| N 220 | <p>Continued From page 20</p> <p>facility to inform the Administrator of the injury to Resident #6's shoulder. The facility initiated an investigation on 02/12/14 and interviewed all staff who had provided care for Resident #6 from 02/06-11/14. Based on the findings of the facility's investigation, the facility determined Certified Nurse Aide (CNA) #1 and CNA #2 had transferred Resident #6 from a Broda chair (chair that reduces pressure and provides long-term sitting support) to the bed on 02/11/14 at approximately 7:00 PM. However, according to the facility's investigation, CNAs #1 and #2 failed to follow the Plan of Care that had been developed for Resident #6 as they failed to use a mechanical lift when they transferred the resident to bed. The investigation further revealed when Registered Nurse (RN) #3 entered Resident #6's room on 02/11/14 at approximately 9:00 PM to monitor the resident's blood glucose levels, the resident pulled his/her gown down from the right shoulder area with his/her left hand. The nurse observed "new" bruising and swelling to the resident's right shoulder area.</p> <p>Observation of a skin assessment conducted by facility staff on 02/18/14, at 11:10 AM, revealed Resident #6 had a raised area measuring 13 centimeters (cm) by 10 cm on the anterior area of the right shoulder; fading dark purple bruising measuring 3.5 cm by 9 cm near the right axilla; a 22 cm by 10.5 cm yellowish fading discoloration across the resident's upper chest area; a 16 cm yellow fading discolored area extending down the resident's right upper arm; and a 16 cm by 10 cm yellow/purplish area on the right side under the resident's rib cage.</p> <p>Review of documentation by nursing staff in Resident #6's medical record dated 02/11/14, at 9:04 PM, revealed RN #3 entered the resident's</p> | N 220 | <p>thorough skin assessments, with measurements of any identified bruising for monitoring purposes. Any changes in skin status or declines in the healing status of bruises are to be reported to the physician.</p> <p>-The maintenance staff have received in-service education by the administrator on 02/21/14 regarding the need to inspect the water heater units monthly to determine they are maintaining water temperatures within the required parameters, and to test water temperatures randomly throughout the facility in accordance with the preventive maintenance logs.</p> <p>-The facility Safety Committee meets quarterly to review potential safety issues throughout the facility and to develop and implement a Plan of Action for any identified issues. The Safety Committee findings are presented to the QA Committee for review.</p> <p>Criteria 4: -A CQI Meeting with the Medical Director and CQI team was held on 2-13-14 to review the facility investigation and the Plan of Correction</p> | |

Office of Inspector General

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 |
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| N 220 | <p>Continued From page 21</p> <p>room to assess the resident's blood glucose level and noted the resident had discoloration and edema of the right shoulder. Further review revealed RN #3 notified the physician and arranged for the resident to be transferred to the hospital's ED for further evaluation and treatment.</p> <p>Review of the ED record dated 02/11/14, revealed Resident #6 was assessed to have a large amount of ecchymosis (bruising) and a "firm/swollen" area of the right shoulder. X-rays obtained at the ED revealed no evidence of a fracture or dislocation of the right shoulder. Further review of the ED report revealed the resident was admitted to the hospital on 02/11/14 for observation.</p> <p>Review of Resident #6's Attending Physician's Progress Note, dated 02/11/14, revealed the physician assessed Resident #6 to have a hematoma (bruising) to the right anterior chest with bruising to the right upper arm. Further review of the Physician's Progress Note revealed the cause of the bruising "appeared to be a torn muscle/tendon." The physician further noted the tear was probably associated with moving or pulling the resident up in bed or a wheelchair.</p> <p>Interview conducted with CNA #1 on 02/18/14, at 3:55 PM, revealed staff should review the CNA care plan each shift to determine the care needs of each resident. According to CNA #1, the CNA care plan included the requirements staff was to follow for each resident's transfer. CNA #1 stated he had not looked at Resident #6's care plan "in a while" and did not know a mechanical lift was to be used for transfers for Resident #6. CNA #1 stated he and CNA #2 transferred Resident #6 from the Broda chair to the bed at approximately 7:00 PM on 02/11/14. CNA #1 stated he and</p> | N 220 | <p>-The CQI indicator for the monitoring of provision of resident care in accordance with the care plan (such as use of lifts, type and number of staff assistance, use of devices, dietary restrictions etc.) will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>-The CQI indicator for the monitoring of facility water temperatures within the required range of 100-110°F will be utilized monthly X 2 months, and then every six months as per the established CQI calendar under the supervision of the Maintenance Director. Water temperatures will also be checked and documented daily by maintenance or designated staff.</p> <p>- Failure to achieve the established threshold for the CQI indicator(s) will result in development and implementation of a Plan of Action, and a repeat of the indicator(s) within 1-2 months to verify effectiveness.</p> <p>Criteria 5: March 3, 2014</p> | |

Office of Inspector General

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 |
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| N 220 | <p>Continued From page 22</p> <p>CNA #2 had placed one arm underneath the resident's arms and placed a hand on the resident's waistband, and assisted the resident to transfer from the chair to the bed. CNA #1 confirmed he did not see any bruises or swelling on the resident's right shoulder area. CNA #1 further stated the resident did not indicate any injury or pain had occurred during the transfer.</p> <p>Interview conducted with CNA #2 on 02/18/14, at 4:15 PM, revealed she was aware Resident #6 was to be transferred at all times with a mechanical lift. CNA #2 stated she assisted CNA #1 to transfer Resident #6 from the Broda chair to the bed on 02/11/14, at approximately 7:00 PM and a mechanical lift had not been used during the transfer. CNA #2 stated she did not tell CNA #1 staff was to use a mechanical lift when they transferred Resident #6 and offered no explanation as to why they had not used the mechanical lift.</p> <p>Interview conducted with RN #3 on 02/19/14, at 3:30 PM, revealed she had worked the 7:00 PM to 7:00 AM shift on 02/11/14. RN #3 stated Resident #6 was in bed when she went to the resident's room to check his/her blood glucose level at approximately 8:45 PM on 02/11/14. RN #3 stated after she obtained the results of the resident's blood glucose, she proceeded to administer insulin to the resident. The resident placed his/her left hand on the neck of his/her gown and pulled the gown down below the right breast area. The RN stated she observed edema and "a hard knot" on the resident's right shoulder and right breast area with dark purplish/red discoloration noted primarily to the resident's right armpit. RN #3 stated although the resident was able to verbalize pain at times, the resident "mumbled" and did not verbalize he/she was in</p> | N 220 | | |

Office of Inspector General

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| N 220 | <p>Continued From page 23</p> <p>pain when asked if his/her right arm hurt. The RN stated she did not know what had caused the discoloration of the resident's right shoulder and breast and had not attempted to raise the resident's arm to assess further due to not knowing the extent of the injury. RN #3 stated she notified the resident's attending physician and arranged for the resident to be transferred to the ED. RN #3 further stated she received a call from the ED physician on 02/11/14 at approximately 11:00 PM, and the ED physician wanted to know what had caused the swelling and bruising to the resident's right shoulder. According to RN #3, she told the ED physician she did not know and the ED physician stated he was admitting the resident to the hospital for observation.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/20/14, at 9:05 AM, revealed she provided orientation to new employees and also observed employees on an annual basis perform competency skills to evaluate their ability to provide resident care. LPN #2 stated transfer procedures, following the care plan, and mechanical lift procedures were included in the training and annual competency skills checks. LPN #2 also stated she conducted "spot checks" daily to verify staff transferred residents according to their individual plan of care and she had not identified any problems.</p> <p>Review of the Annual Competency Check List completed on 01/15/14 for CNA #1, and for CNA #2 on 10/22/13, revealed the facility had assessed the CNAs to be competent in the use of the mechanical lift.</p> <p>Interview conducted with Physician #1 on 02/19/14, at 1:40 PM, revealed he was Resident</p> | N 220 | | |

Office of Inspector General

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| N 220 | <p>Continued From page 24</p> <p>#6's attending physician and had been contacted by the ED physician on 02/11/14 regarding Resident #6's injury. Physician #1 stated the ED physician said he did not know what had caused the resident's injury. Physician #1 stated he assessed Resident #6 on 02/12/14 and determined the injury was due to a torn pectoral muscle, and called the facility's Administrator to report the injury. He further stated the torn pectoral muscle most likely occurred when staff lifted Resident #6. Physician #1 stated the injury could have been prevented if the resident had been transferred with a mechanical lift.</p> <p>Interview conducted with the Administrator on 02/20/14, at 4:10 PM, revealed Physician #1 informed him the injury sustained by Resident #6 on 02/12/14 was due to a torn pectoral muscle. The Administrator stated a facility investigation was initiated and determined CNAs #1 and #2 failed to transfer Resident #6 using a mechanical lift on 02/11/14. The Administrator stated CNA #1 and CNA #2 had been suspended immediately and remained on suspension pending further investigation.</p> <p>2. Observations conducted on 02/18/14 at 1:00 PM revealed the hot water temperature in the women's shower room located on Station II was 132 degrees Fahrenheit (F) (22 degrees higher than the acceptable temperature range of 110 degrees Fahrenheit); the hot water temperature in the men's shower room located on Station II was observed to be 120 degrees F; and the hot water temperature in resident room 221 was observed to be 122 degrees F. Additional observations of the women and men's shower rooms and resident room 221, conducted with the Maintenance Director on 02/18/14 at 1:15 PM, revealed the hot water temperature fluctuated</p> | N 220 | | |

Office of Inspector General

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| N 220 | <p>Continued From page 25</p> <p>from 90 degrees to 117 degrees F (10 degrees below and 17 degrees higher than the acceptable range).</p> <p>Review of the facility's census report on 02/18/14 revealed 18 residents resided on the two hallways located at Station II and had access to the shower rooms.</p> <p>Review of the Monthly Preventative Maintenance Checklist completed in December 2013, January 2014, and through February 18, 2014 revealed the hot water temperatures had been within normal limits.</p> <p>Interview conducted with the Maintenance Director on 02/18/14 at 1:30 PM (EST) revealed the hot water temperatures in the facility were maintained at 100-110 degrees F. According to the Maintenance Director, he had obtained the hot water temperatures located in resident rooms (rooms 106, 216, and 114) on Stations I and II on the morning of 02/18/14 and had not identified any concerns. Further interview with the Maintenance Director revealed the mixing valve on the hot water heater might have failed since he had obtained the temperatures, and he had shut the hot water to the Station II hallway off until the repairs could be completed. The Maintenance Director stated he had ordered the defective part for the mixing valve on 02/18/14 and expected it to be delivered to the facility on 02/21/14. The Maintenance Director also stated he had directed staff to use the shower rooms on Station I for bathing residents until the repairs were made.</p> <p>An interview conducted with the Administrator on 02/20/14 at 3:47 PM revealed he had not received any complaints about water</p> | N 220 | | |

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100471 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 | | |
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| N 220 | Continued From page 26 temperatures. The Administrator stated he had not been aware of any concerns with the hot water temperatures or the failure of the mixing valves until the Maintenance Director had informed him on 02/20/14. | N 220 | | |

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

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|-------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------|
| (Y1) Provider / Supplier / CLIA / Identification Number 185270 | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit 4/16/2014 |
| Name of Facility CUMBERLAND VALLEY MANOR | | Street Address, City, State, Zip Code 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|-------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------|------------------------------------|
| ID Prefix <u>F0257</u> Reg. # <u>483.15(h)(6)</u> LSC _____ | Correction Completed 03/03/2014 | ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____ | Correction Completed 03/03/2014 | ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____ | Correction Completed 03/03/2014 |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
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| Reviewed By <input checked="" type="checkbox"/> State Agency | Reviewed By <u>MH</u> | Date: <u>04/23/14</u> | Signature of Surveyor: <u>Marie Hopkins</u> | Date: <u>04/23/14</u> |
| Reviewed By _____ CMS RO | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

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| Followup to Survey Completed on: 2/20/2014 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
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State Form: Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number 100471 | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit 4/16/2014 |
| Name of Facility CUMBERLAND VALLEY MANOR | Street Address, City, State, Zip Code 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 | |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|-------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------|---------------------------------------|
| ID Prefix <u>N0137</u> Reg. # <u>902 KAR 20:300-8(7)(a)5.</u> LSC _____ | Correction Completed 03/03/2014 | ID Prefix <u>N0194</u> Reg. # <u>902 KAR 20:300-7(4)(c)2.</u> LSC _____ | Correction Completed 03/03/2014 | ID Prefix <u>N0219</u> Reg. # <u>902 KAR 20:300-8(7)(a)</u> LSC _____ | Correction Completed 03/03/2014 |
| ID Prefix <u>N0220</u> Reg. # <u>902 KAR 20:300-8(7)(b)</u> LSC _____ | Correction Completed 03/03/2014 | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
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| Reviewed By <input checked="" type="checkbox"/> | Reviewed By <u>my</u> | Date: <u>04/23/14</u> | Signature of Surveyor: <u>Mandi Hobens</u> | Date: <u>04/23/14</u> |
| Reviewed By _____ | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

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|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Followup to Survey Completed on: 2/20/2014 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table> | YES | NO |
| YES | NO | | |

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED 02/18/2014 |
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 361 SOUTH MAIN STREET BURKEVILLE, KY 42717 | |
| (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: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Six SUPERVISED AUTOMATIC ADDRESSIBLE FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Two Type II Diesel generators A Life Safety Code Survey was initiated and concluded on 02/18/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at a scope and severity of "D". | K 000 | Plan of Correction Cumberland Valley Manner Standard Survey 2/20/14 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD | K 038 | K 038 NFPA 101 Life Safety Code Standard Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. | |

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

TITLE

(X6) DATE

[Signature]

Administrator

03/18/14

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.

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/18/2014 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 | | |
| (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 038 | <p>Continued From page 1</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits as required. This deficient practice affected three of six smoke compartments, staff, and approximately 25 residents. The facility has the capacity for 84 beds with a census of 83 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/18/14 at 9:55 AM with the Director of Maintenance (DOM), milk crates were observed to be stacked outside the back kitchen door in an exterior egress walkway. Exits must be maintained in case of fire or other emergency.</p> <p>An interview with the DOM on 02/18/14 at 9:55 AM, revealed he has repeatedly told staff about maintaining exits during safety meetings.</p> <p>During the survey, chairs were observed to be blocking the dining room exit. In addition, carts and lifts were observed to be not in use for over one-half hour in the 200 Hallway.</p> <p>The findings were revealed to the Administrator</p> | K 038 | <p><i>Criteria 1 and 2:</i> -The milk crates outside the back kitchen door were removed. - Resident equipment is stored in storage areas when not in use. -Chairs in the dining room are stored away from the dining room exit.</p> <p><i>Criteria 3:</i> Facility staff have received in-service education as provided by the Maintenance Supervisor and Administrator on February 21-23, 2014 on the proper storage of milk crates, dining room chairs, and resident equipment when not in use.</p> <p><i>Criteria 4:</i> The CQI indicator for the monitoring of proper storage of resident furniture and equipment when not in use, will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p><i>Criteria 5:</i> February 24, 2014</p> | |

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/18/2014 |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 | | |
| (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 038 | Continued From page 2 upon exit. Reference: NFPA 101 (2000 Edition). 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. | K 038 | | | |

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| | | |
|-------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------|
| (Y1) Provider / Supplier / CLIA / Identification Number 185270 | (Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing | (Y3) Date of Revisit 3/13/2014 <i>by mail</i> |
|-------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|---------------------------------------------|-----------------------------------------------------------------------------------------|
| Name of Facility CUMBERLAND VALLEY MANOR | Street Address, City, State, Zip Code 301 SOUTH MAIN STREET BURKESVILLE, KY 42717 |
|---------------------------------------------|-----------------------------------------------------------------------------------------|

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------|----------------------------------------------|----------------------|
| ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0038</u> | Correction Completed <u>02/24/2014</u> | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
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| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |

| | | | | |
|-----------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------------|--------------------------|
| Reviewed By <input checked="" type="checkbox"/> State Agency | Reviewed By <u>MH</u> | Date: <u>04/23/14</u> | Signature of Surveyor: <u>Maria Hopkins</u> | Date: <u>04/23/14</u> |
| Reviewed By _____ CMS RO | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

| | |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| Followup to Survey Completed on: <u>2/18/2014</u> | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
<http://chfs.ky.gov/os/oig>

Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

April 23, 2014

Mr. Paul Shepard
Cumberland Valley Manor
301 South Main Street
P O Box 438
Burkesville, Kentucky 42717

Dear Mr. Shepard:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on February 20, 2014. Upon reviewing this plan, we found it to be acceptable.

Based on implementation of your plan of correction, and the revisit completed on April 16, 2014, it was determined your facility had achieved compliance as of March 3, 2014. Therefore, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX program(s).

Your cooperation is appreciated. If you have any questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Sandy Goins" with a stylized flourish.

Sandy Goins
Regional Program Manager

SG:md:lk

Enclosure



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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116 Commerce Avenue
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

March 21, 2014

ELECTRONIC MAIL (pshepard@cumberlandvalleymanor.com)

Mr. Paul Shepard
Cumberland Valley Manor
301 South Main Street
P O Box 438
Burkesville, Kentucky 42717

Dear Mr. Shepard:

The Division of Health Care has received your facility's plan of correction regarding the deficiencies identified during the standard survey completed on February 20, 2014. The plan of correction submitted was determined to be unacceptable.

As you were informed in the March 6, 2014 letter accompanying the CMS-2567/Statement of Deficiencies, your plan of correction must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice;
- How you will identify other residents/patients having the potential to be affected by the same deficient practice;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

Your plan of correction is being returned for amendment, as it did not meet the above criteria as follows:

F257/N137--

Criterion #3 - The Plan of Correction revealed the maintenance staff will monitor the thermostats in resident common areas on a weekly basis and bring discrepancies to the attention of the Administrator. The Plan failed to reveal if the temperatures taken on a weekly basis would be documented, or the method that would be used to notify the Administrator of discrepancies.

Criterion #4 - The Plan of Correction revealed CQI indicators for the monitoring of the facility temperatures would be utilized. The Plan failed to indicate what criteria was included in the CQI tool or what actions the facility would take if facility temperatures were not within acceptable ranges.

F282/N194--

Criterion #2 - The Plan of Correction addressed the example cited related to mechanical lifts; however, the Plan failed to address how the facility would identify other residents that have the potential to be affected by the facility's failure to ensure services were provided in accordance with a written Plan of Care. The Plan of Correction must address the regulation, not just the example provided.

Criterion #3 - The Plan of Correction addressed the example cited related to mechanical lifts; however, the Plan failed to address what measures and/or systemic changes would be put into place to ensure services were provided in accordance with a written Plan of Care. The Plan of Correction must address the regulation, not just the example provided.

Criterion #4 - The Plan of Correction addressed the example cited related to mechanical lifts; however, the Plan failed to address how the facility planned to monitor its performance to ensure services were provided in accordance with a written Plan of Care. The Plan of Correction also failed to indicate what criteria was included in the CQI tool used for monitoring, or what actions the facility would take if problems were identified during the monitoring process. The Plan of Correction must address the regulation, not just the example provided.

F323/N219 & N220--

Criterion #2 - The Plan of Correction addressed the example cited related to mechanical lifts/water temperatures; however, the Plan failed to address how the facility would identify other residents that have the potential to be affected by the facility's failure to ensure the residents' environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The Plan of Correction must address the regulation, not just the example provided.

Mr. Paul Shepard
March 21, 2014
Page Three

Criterion #3 - The Plan of Correction addressed the example cited related to mechanical lifts/water temperatures; however, the Plan failed to address what measures and/or systemic changes would be put into place to ensure the residents' environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The Plan of Correction must address the regulation, not just the example provided.

Criterion #4 - The Plan of Correction addressed the example cited related to mechanical lifts/water temperatures; however, the Plan failed to address how the facility planned to monitor its performance to ensure the residents' environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The Plan of Correction also failed to indicate what criteria was included in the CQI tool used for monitoring, and what actions the facility would take if problems were identified during the monitoring process. The Plan of Correction must address the regulation, not just the example provided.

902 KAR 20:008 Section 2.(5)(b) and/or 42 CFR 488.28, 42 CFR 456, and 42 CFR 489.453 requires that you submit a modified or amended plan of correction within ten (10) days of receipt of this notice that the previously submitted plan of correction was unacceptable. **Failure to submit an acceptable plan of correction within ten (10) days of receipt of this letter will result in a recommendation that action be taken against your state-issued license and/or your Medicare provider agreement be terminated.**

If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Sandy Goins" followed by a stylized flourish.

Sandy Goins
Regional Program Manager

SG:md:lk

Enclosures



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

March 6, 2014

ELECTRONIC MAIL (pshepard@cumberlandvalleymanor.com)

Mr. Paul Shepard
Cumberland Valley Manor
301 South Main Street
P O Box 438
Burkesville, Kentucky 42717

Dear Mr. Shepard:

On February 20, 2014, a standard survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby significant corrections are required (G).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted no later than ten (10) days from receipt of this letter. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

Mr. Paul Shepard
March 6, 2014
Page Two

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, we are recommending to the Centers for Medicare and Medicaid Services (CMS) Regional Office the following:

- A civil money penalty of an amount and duration to be determined by CMS.
- Denial of payment for new admissions as soon as notification requirements can be met.

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedy(ies). If this occurs, you will be notified.

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

Mr. Paul Shepard
March 6, 2014
Page Three

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Sandy Goins
Regional Program Manager

SG:md:ik

Enclosures

c: CMS Regional Office



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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116 Commerce Avenue
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

March 6, 2014

Mr. Paul Shepard
Cumberland Valley Manor
301 South Main Street
P O Box 438
Burkesville, Kentucky 42717

Dear Mr. Shepard:

The Division of Health Care completed a relicensure survey at your facility on February 20, 2014. This survey was conducted to determine compliance with state licensure requirements. The survey found that your facility failed to meet minimum state licensure requirements for operation of a nursing facility. The deficiencies cited are listed on the enclosed Statement of Deficiencies/Plan of Correction document.

As part of the licensure process, each facility is required to submit a written plan for the correction of all deficiencies noted during the survey. The Plan of Correction shall specify:

- The date by which the violation shall be corrected,
- The specific measures utilized to correct the violation, and
- The specific measures utilized to ensure the violation will not recur.

Mr. Paul Shepard
March 6, 2014
Page Two

902 KAR 20:008 Section 2.(5)(b) requires that a plan of correction for licensure deficiencies be submitted to this agency within ten (10) days from receipt of this letter. The plan, outlining methods of correction and proposed completion dates for each deficiency, should be incorporated in the column provided on the enclosed form. The form should be signed by you or an authorized representative and received in this office within ten (10) days of receipt of this letter. You should make a copy of the form for your records and/or posting requirements. Continued failure to meet minimum state licensure requirements will result in a recommendation for revocation of a license to operate a nursing facility.

KRS 216.547 requires that all long-term care facilities shall retain, for public inspection in the office of the administrator and in the lobby of the facility, a complete copy of every inspection report of the facility received from the cabinet during the past three (3) years, including the most recent inspection report.

Informal Dispute Resolution (IDR): In accordance with 906 KAR 1:120, a long-term care facility shall have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send a written request which specifies the deficiency in dispute; explain the dispute and provide a detailed basis for the dispute; specify the format desired (refer to the enclosure) and attach the documentation in support of your position to the request. This written request and attachments shall be delivered to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621 on or before the mandated return date for the plan of correction. Informal Dispute Resolution will be accomplished in accordance with 906 KAR 1:120. This process will not delay the effective date of any enforcement action.

IDR in no way is to be construed as a formal evidentiary hearing. It is an informal process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for IDR so that we may also have counsel present. You will be advised verbally of your decision relative to the informal dispute, with written confirmation to follow.

If you should have questions regarding this information, please contact our office.

Sincerely,



Sandy Goins
Regional Program Manager

SG:md:lk

Enclosure

COMPLIANCE REPORT FOR INSTITUTIONAL FACILITIES
(Civil Rights Act Title VI)

IDENTIFYING INFORMATION

Name of Facility: Cumberland Valley Nur Paul Shepard
 Chief Administrative Officer
 Telephone No. 270 864 4315
 Medicare Provider No. 185070 Title Adm.
 Licensed Bed Capacity 84 (number)
 Name, Address and Telephone Number of Owner of Facility
N/A

1. What is the approximate nonwhite population in the service area? 1%
2. Have you notified the general public, in writing, that your facility will admit and service patients equally, without regard to race, color, or national origin? Yes No
3. If "Yes" check method of communication: Newspaper Letter Other (Specify) Date Jan 2014
4. Is the use of this facility limited to membership in a defined group? (i.e., fraternal organization, religious denomination, employees of a corporation, etc.) Yes No
5. If "Yes" explain and define membership requirements under remarks.

REMARKS
(Use bond paper if more space is needed.)

6. Does this facility admit patients without regard to race, color, or national origin? Yes No
7. List below the facility's chief referral sources (such as doctors, hospitals, other nursing home, local welfare departments, etc.)

| Name of referring individual or institutions | Address | Person actually making the contact with this facility |
|----------------------------------------------|---------|-------------------------------------------------------|
| <u>Cumb Co Hosp</u> | | |
| <u>Clinton G HBSP</u> | | |
| <u>local doctor</u> | | |
| <u>in Cumberland</u> | | |
| <u>+ Clinton Co.</u> | | |
8. Have all of the above referral sources been notified, in writing, of this facility's policy of admitting all patients without regard to race, color, or national origin? Yes No

9. Do any of the persons who receive referrals in this facility inquire about the race of the person being referred before providing information on space available in the facility? Yes No
10. How many persons are on the waiting list? Total 0 Asian African American American Indian Spanish Surnamed American
11. Has the person responsible for patient placement in this facility been instructed to assign patients to room accommodations without regard to race, color, or national origin? Yes No
12. Are patients asked whether they are willing to share a room with a patient of a different race? Yes No
13. Are all private rooms available to both white and nonwhite patients? Yes No
14. Are patients routinely assigned to 2-bed, 3-bed, and ward rooms without regard to race, color, or national origin? Yes No
15. Do you transfer patients because they object to sharing rooms with patients of a different race? Yes No
16. Total number of patients in today's census: White 81 African American 2 American Indian Asian Spanish Surnamed American Other

17. Indicate below the number of minority group patients or beneficiaries in today's census by type of room assignment according to the following breakdown

| Type of Room Assignment | African American | Indian American | Asian | Spanish Surnamed American |
|-------------------------------------------------------------------------------------------------------------------|------------------|-----------------|-------|---------------------------|
| Number of minority patients or beneficiaries in single rooms or in room alone | | | | |
| Number of minority patients or beneficiaries in semi-private or ward rooms having only minority person. | <u>2</u> | | | |
| Number of minority patients or beneficiaries in semi-private or ward rooms with one or more non-minority persons. | | | | |
| Total | <u>2</u> | | | |

18. Estimate the number of patients or beneficiaries of the minority groups admitted during the past year:

| Type of aid | Total | African American | Indian American | Asian | Spanish Surnamed American |
|-------------|----------|------------------|-----------------|-------|---------------------------|
| Medicare | <u>0</u> | | | | |
| Medicaid | <u>2</u> | <u>2</u> | | | |

19. Does this facility have more than one dining room used by patients? 0 1-10 11-20 21-50 Over 50
 Yes No
20. If you have one patient dining room, is it used by persons of different races simultaneously? Yes No
21. If you have more than one patient dining room (give number 3), is one used predominately by one race? Yes No
22. Are all services and facilities used routinely by all persons without regard to race, color, or national origin (i.e., nursing care, social services, occupational therapy, lounges, barber shops, beauty salons, etc.)? Yes No
23. If "No" specify which are not.

24. Are services rendered in this facility without regard to the race of either the patient or the person rendering the service? Yes No
25. If "No" specify which services are not.

26. Is the use of courtesy title (Mr., Mrs., etc.) uniform throughout this facility on records, news releases, public address systems, name tags, etc., and in addressing patients? Yes No

27. Estimate below the number of physicians and other licensed paramedical personnel not on your payroll that gave patient service in this facility during the last month by race of the physician or person rendering the service.

| Physicians and Other Non-Salaried Paramedical Personnel | Total | African American | American Indian | Asian | Spanish Surnamed American |
|---------------------------------------------------------|-------|------------------|-----------------|-------|---------------------------|
| | 0 | | | | |

28. Has the staff been notified, in writing, of the facility's policies as they apply to the Civil Rights Act of 1964? Yes No
29. Are referrals to other facilities and services (e.g., skilled, intermediate, or residential care facilities) made routinely without consideration of the race of the patient? Yes No
30. Are referrals made to other facilities or services which consider race in the acceptance of patients? Yes No

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Signature of Authorized Official _____ Title Administrator Date 2/18/2014

Signature of Reviewer Maya Billie NCJ Title of Reviewer _____

Facility Name Cumberland Valley Manor

**CHECKLIST FOR COMPLIANCE WITH KRS 214.620 (4)
HIV/AIDS PATIENT INFORMATION**

DISTRIBUTION METHOD

YES NO Agency uses patient information form developed by the Department for Health Services

YES NO Agency uses their own patient information form.

YES NO Agency distributes patient information in admissions package.

AGENCY FORM INCLUDES THE FOLLOWING INFORMATION

METHODS OF TRANSMISSION:

YES NO sexual contact (anal, oral, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretions are exchanged;

YES NO sharing a syringe/needle with someone who is infected;

YES NO infected mother may pass HIV to unborn child; and

YES NO receiving contaminated blood or blood products, organ/tissue transplants, and artificial insemination (rare now since testing for HIV antibodies began).

METHODS OF PREVENTION:

YES NO no sexual intercourse except with a monogamous partner who is not infected;

YES NO sexual relations with anyone else requires use of latex condom, female condom, or dental dam;

YES NO do not share syringes or needles with anyone;

YES NO should be tested for HIV if pregnant or plan to be pregnant; and

YES NO education of self & others about HIV infection & AIDS.

APPROPRIATE ATTITUDES & BEHAVIORS

YES NO assurances that the agency provides quality services to all patients, regardless of HIV status.

