

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

PRINTED: 06/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted 06/15-17/10. Deficiencies were cited, with the highest S/S being a "G".	F 000	Disclaimer: 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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 Notification of Changes The facility shall immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is (A) An accident involving the resident which results in injury and has the potential for requiring physician interventions; (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment significantly; or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a). Criteria #1: Resident #3's MD is aware of her current condition. Criteria #2: An audit of the facility laxative logs and BM Monitoring logs for the past month has been completed to identify any residents having episodes of constipation. An audit of Alert Documentation Logs and Shift Reports from past month has been completed to identify any residents with a	



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

[Handwritten Signature]

TITLE

[Handwritten Title]

(X6) DATE

7/9/10

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record review, it was determined the facility failed to immediately notify the physician regarding a significant change in condition and the potential for alteration in treatment for one resident (#3) in the selected sample of 10. The facility assessed Resident #3 as exhibiting symptoms of abdominal distention, abdominal pain, decreased bowel sounds and no bowel movement (BM) for six days. The facility failed to follow it's Physician/Legal Representative Notification policy and procedure by not notifying the physician of Resident #3's abdominal pain and not notifying the physician prior to administering four enemas. On 02/12/10, after the facility administered the enema, the resident's oxygen (O2) saturation (sat.) level dropped to 56-62% (normal 90%-100%). The facility called the physician three days after the facility had identified the resident was having abdominal pain and no results from a soap suds enema. Resident #3 was sent to the hospital and diagnosed with Urinary Retention and Constipation.</p> <p>Findings include:</p> <p>A review of the nursing facility's Physician/Legal Representative Notification policy and procedure, last revised 08/06, revealed it was the policy of the facility to immediately consult with the resident's physician when there was a significant change in the resident's physical status (deterioration in health status in life threatening conditions or clinical complications) and when there was a need to alter treatment significantly (commence a new form of treatment).</p> <p>A review of the facility's nurse's note, dated</p>	F 157	<p>change in condition.</p> <p>Notification of the resident's physician and legal responsible party was done as indicated for any change in condition which would indicate the need to notify the physician and legal representative.</p> <p>Criteria #3: The facility's BM Monitoring Log has been revised to allow for documentation of LN/KMA daily review of Log. All nursing staff members have received in-service education provided by the DON/ADON on the revisions to the log.</p> <p>LN's have received in-service education provided by the DON/ADON on the facility's Physician Notification Policy and Constipation Protocol.</p> <p>Criteria #4: The CQI indicator for monitoring of physician notification shall be completed monthly X 2, then every 6 months as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date</p>	7/23/10

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F 157	<p>Continued From page 2</p> <p>02/13/10 at 4:27 AM, revealed the Emergency Room Nurse reported to the facility that a large amount of BM was removed from the resident's rectum. A review of the emergency room report, dated 02/13/10, revealed the resident was diagnosed with Urinary Retention and Constipation.</p> <p>A record review revealed Resident #3 was admitted to the facility on 05/12/09 with diagnoses to include Dementia with Psychotic agitated features and Constipation. A review of the initial Minimum Data Set (MDS) assessment, dated 05/25/09, revealed the facility identified Resident #3 as moderately cognitively impaired, which affected the resident's ability to make decisions. The assessment detailed the resident was continent of bowel.</p> <p>A review of the February 2010 BM log and nurse's notes, dated 02/06/10, revealed the resident's last BM was on 02/06/10, after a soap suds enema was administered because the resident was complaining of abdominal pain. The resident was assessed and it was determined the resident's abdomen was distended with hypoactive bowel sounds. Record review revealed no evidence the physician was contacted, prior to administration of the enema.</p> <p>Further review of the nurse's notes and February 2010 BM log, revealed Resident #3 had no BMs for the next six days (02/06-02/12/10). The nurse's notes revealed the facility assessed the resident during this period of time, on 02/08/10 and 02/10/10, and determined Resident #3 continued to experience abdominal pain, abdominal distention and hypoactive bowel sounds. The nurse's notes revealed the facility</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>administered a soap suds enema on both occasions, with no results obtained. Further record review revealed no documented evidence the facility consulted with the physician to make him aware Resident #3 was experiencing abdominal distention, abdominal pain, decreased bowels sounds and that no results were obtained from the administration of the soap suds enemas.</p> <p>A review of the nurse's note, dated 02/12/10 at 10:45 AM, revealed the facility faxed the physician to make him aware the resident was having "problems with no BM, abdominal distention and decreased bowel sounds in all four quadrants", with no mention of the resident's abdominal pain. Further record review revealed no evidence the facility received a physician's response to the fax and no evidence the facility made any further attempts to consult with the physician regarding the resident's condition.</p> <p>A review of the nurse's note, dated 02/12/10 at 9:00 PM, revealed the facility assessed the resident and determined the resident's abdomen was very distended, the resident grimaced when the abdomen was palpated and auscultation of the abdomen revealed very little bowel sounds could be heard. The nurse's note revealed the nurse attempted to administer a soap suds enema but the water (from the enema) would not go into the rectum. Further review revealed there was no documented evidence the facility consulted with the physician, prior to administration of the soap suds enema, even though the resident was experiencing abdominal pain with palpation. Resident #3 began experiencing labored breathing, with the resident's O2 sat. assessed at 56%-62%. Oxygen was administered at three liters a minute, the physician was notified and the</p>	F 157		

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F 157	<p>Continued From page 4 resident was sent to the emergency room.</p> <p>A review of the hospital x-ray report, dated 02/13/10, revealed the resident's bladder was very distended and it appeared the distention of the bladder caused displacement of the bowel loops.</p> <p>An interview with Registered Nurse (RN) #2, on 06/17/10 at 8:55 AM, revealed she was unable to recall the number of days the resident had no BM, when she administered the soap suds enema on 02/12/10. She stated she could not remember if the physician was notified of the resident's condition. She stated she assessed Resident #3, on 02/12/10 and the resident's abdomen was very distended, the resident expressed pain when she palpated the abdomen. She stated she heard very little bowel sounds. She stated she did not notify the physician of the assessment findings. She stated the facility had a constipation protocol, but she did not recall the last time she had read it. She stated when she tried to administer the enema, the water would not go into the rectum/colon. She decided the physician would be notified the next morning. The Certified Nurse Aide came to the nurse's desk a few minutes later and made her aware the resident was having difficulty breathing and the resident's O2 sat. was very low.</p> <p>Interviews with RN #1, Licensed Practical Nurse (LPN) #2, LPN #3 and LPN #4, on 06/16/10 at 3:10 PM, 3:15 PM and 3:45 PM and on 06/17/10 at 10:00 AM and 11:00 AM respectively revealed they did not recall notifying the physician regarding Resident #3 having no BM and experiencing symptoms of pain, distention and decreased bowels sounds. They stated they</p>	F 157		

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F 157	Continued From page 5 usually notified the physician by fax rather than phone. If there was no response to the fax in 24 hours, they would call the physician by phone. They revealed they would have called the physician if the resident had abdominal pain prior to administration of an enema. LPN #4 stated she sent the fax to the physician, on 02/12/10 at 10:45 AM, and had not received a response from the physician, prior to leaving the facility at 7:00 PM. An interview with the Director of Nursing, on 06/17/10 at 11:00 AM, revealed the physician should have been notified when the resident was assessed with having abdominal pain, prior to giving the enemas, on 02/08/10 and 02/10/10. The nurse also should have faxed the physician when the resident had no results, after the enemas were administered, on 02/08/10 and 02/10/10. If the nurse had not received a response from the physician within 24 hours, the nurse should have called the physician to make him aware and determine if any further orders were needed. The nurse should not have administered an enema to the resident without first calling the physician, when the resident was assessed as experiencing abdominal pain. An interview with Resident #3's primary physician, on 06/17/10 at 3:30 PM, revealed he would have expected the nurse to notify him when the resident was experiencing abdominal pain prior to the enemas, when there was no results from the first enema and each time an enema was administered and ineffective after that. Additionally, he stated the nurse should have notified him when she was unable to get the water to enter the rectum/colon.	F 157		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 6 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation; interview and record review, it was determined the facility failed to ensure services provided meet professional standards of quality related to physician orders not followed for one resident (#11), not in the selected sample of 10. Resident #11 was administered 8 units (U) of insulin instead of the 10 units prescribed by the physician. Findings include: An observation of a medication pass, conducted 06/16/10 at approximately 11:00 AM, revealed Resident #11's blood sugar was 364. Registered Nurse (RN) #1 was observed to administer 8 U of Novolin R insulin to Resident #11. A review of the resident's physician's orders, dated 06/10, revealed a sliding scale insulin order as follows: 150-200=2U 201-250=4U 251-300=6U 301-350=8U >351=10U An interview with RN #1, on 06/16/10 at approximately 11:10 AM, revealed she was nervous and didn't read the order correctly and should have administered 10U instead of the 8U she administered.	F 281	F 281 Services Provided Meet Professional Standards The services provided or arranged by the facility shall meet professional standards of quality: Criteria #1: Upon identification of error in insulin dose, resident #11 was given an additional 2 units of insulin to equal a total of 10units as should have been given. Criteria #2: A review of MAR's of residents receiving sliding scale insulin was completed to ensure no error in doses were made during the previous month. Criteria #3: All facility LN's have received in-service education provided by the DON/ADON on Sliding Scale insulin administration. All facility LN's have had skills review/observation for administration of SS Insulin. Criteria #4: The CQI indicator for monitoring of Sliding Scale Insulin administration shall be done monthly X2, then annually and prn as per established CQI calendar under the supervision of the DON. Criteria #5: Target Date	7/23/10

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F 281	Continued From page 7	F 281		
F 282 SS=D	<p>A review of the Medication Administration Procedures (no date) revealed:</p> <p>1. General Procedures to follow for all medications</p> <p>c. Read medication label three times (3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must 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, and record review, it was determined the facility failed to ensure that services provided by the facility were provided according to each resident's written plan of care, for one resident (#2), in the selected sample of 10 residents, related to an alarm not being placed in the resident's recliner and heel lift boots not being applied. The Certified Nursing Assistant (CNA) failed to ensure an alarm was applied to the resident's recliner and failed to ensure heel booties were applied on the resident. Review of the CNA care plan revealed the resident required an alarm to the bed, wheelchair and recliner and booties at all times. Findings include:</p> <p>Resident #2 was admitted to the facility with diagnoses to include Senile Dementia and Anxiety.</p> <p>Observation of Resident #2, on 06/15/10 at 10:30</p>	F 282	<p>F 282 Services by Qualified Persons as per Care Plan</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care:</p> <p>Criteria #1: Resident #2's chair alarm and heel booties are being applied by staff members as per plan of care.</p> <p>Criteria #2: An audit of all residents with alarms and/or pressure reducing devices has been completed to ensure devices are utilized as per plan of care.</p> <p>Criteria #3: All facility CNA/NA's have received in-service education provided by the DON/ADON on providing care as per each resident's plan of care.</p> <p>Criteria #4: The CQI indicator for the monitoring of care plan implementation shall be utilized monthly X 2 months, then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date</p>	7/23/10

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F 282	<p>Continued From page 8</p> <p>AM, revealed he/she was reclined in a recliner awake and alert. An alarm was not observed on the recliner and the resident was not wearing heel lift booties. At 11:40 AM, 4:00 PM, and 4:35 PM, the resident was observed in the dining room for lunch in a wheelchair without the heel lift booties applied. At 2:43 PM and 3:25 PM Resident #2 was observed reclined in the recliner without heel lift booties in place and the alarm was not observed on the recliner. On 06/16/10 at 8:20 AM, the resident was observed in his/her wheelchair awake and alert. The resident did not have heel lift booties applied.</p> <p>A review of Resident #2's quarterly Minimum Data Set (MDS) assessment, dated 03/26/10 and an admission MDS assessment, dated 09/19/09, revealed the resident was severely cognitively impaired and required limited assistance of one staff member with transfers and ambulation. The resident had an accident in the past 31-180 days.</p> <p>A review of Resident #2's CNA care plans, dated January 28, 2010 through June 2010, revealed interventions included a personal safety alarm when in the chair, recliner, and in bed. The CNA care plan also stated the resident was to have booties on at all times, as of 02/22/10.</p> <p>An interview with CNA #4, on 06/15/10 at 5:30 PM, revealed she was providing care for the resident. She stated the resident had an alarm to his/her bed and wheelchair. She stated "If she had an alarm to the recliner you would see the cord on the floor when the resident was seated there." CNA #4 revealed the resident did not have an alarm to the recliner when up. CNA #4 stated the resident wore the heel lift booties when he/she was in bed. No explanation was provided</p>	F 282		

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F 282	Continued From page 9 why the resident did not have the heel lift booties in place and the alarm applied to the recliner. Interviews with Nursing Assistant (NA) #3, on 06/16/10 at 8:40 and 9:20 AM, revealed she provided care for the resident on 06/15/10 and 06/16/10. NA #3 was observed at 8:40 AM to transfer Resident #2 to the recliner from the wheelchair, and did not apply the heel lift boots, and an alarm to the recliner. She reviewed the care plan for the resident. NA #3 stated when she signed the resident's care plan, it indicated she had completed the care for the resident by the care plan. NA #3 stated sometimes the staff placed the alarm from the bed on the recliner, while he/she was in the recliner. She stated, "The resident was doing better and they were leaving the door open so the staff could see him/her as they were in and out of other resident rooms providing care. Resident #2 only wore the heel booties at night when in bed". She stated nobody had informed her the resident wore the booties all the time.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F 309 Quality of Care (continued on next page) F 309 Quality of Care Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and	

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F 309	<p>Continued From page 10</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to provide the necessary care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, for one resident (#3) in the selected sample of 10. The facility failed to provide on-going assessments and provision of services to address symptoms of constipation, according to the facility's Constipation Protocol. The facility assessed Resident #3 as having abdominal pain and no bowel movement (BM) for six days. Three enemas were given without results. On 02/12/10, after administration of a soap suds enema, the resident experienced labored breathing and a critically low oxygen (O2) saturation (sat.) of 56% -62% (normal 90%-100%) . The resident was transported to the hospital three days after the facility identified the resident was having abdominal pain and no results from the administration of soap suds enemas. The resident was sent to the hospital and the resident was diagnosed with bladder distention and constipation. Findings include:</p> <p>A review of the facility's Constipation Protocol, dated 10/05, revealed the 7:00 AM-3:00 PM, staff who were passing medications, should review each resident's BM log and place each resident's name on the laxative list, if the resident has not</p>	F 309	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care:</p> <p>Criteria #1: Resident #3 now has an indwelling catheter for management of urinary retention. He/she is on a routine stool softener for constipation. He/she continues to have occasional episodes of extended periods between BM's due to poor intake; with no signs/symptoms of pain or abdominal distention. Constipation protocol is being followed and the MD is notified per policy.</p> <p>Criteria #2: An audit of the facility's BM and Bladder Monitoring logs for the past month has been completed to identify any residents having episodes of constipation or decrease in urinary output that could cause pain/discomfort. Notification of the resident's physician was done as indicated for any change in condition or level of comfort which would indicate the need to change their current treatment plan.</p> <p>Criteria #3: The facility's BM Monitoring Log has been revised to allow for documentation of LN/KMA daily review of Log. All nursing staff members have received in-service education provided by the DON/ADON on the revisions to the log. LN's have received in-service education provided by the DON/ADON on the</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
(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 facility's Constipation Protocol.	(X5) COMPLETION DATE
F 309	Continued From page 11 had a BM in the last three days. Any resident not having a BM by 2:00 PM-3:00 PM that day, should be offered/administered a laxative ordered by the physician after verifying with the resident that they were not experiencing any symptoms such as: abdominal pain, rectal pain, nausea and vomiting, fever, diarrhea or any other symptom of GI related problems. The laxative list should note the administration of the as needed laxatives and kept with the medication cart until the next morning. The medication pass staff should review this list of administered laxatives before preparing the new laxative list the following day to assure results from all administered laxatives. Review of the protocol revealed it did not address what staff were supposed to do if the resident was exhibiting any GI related symptoms and did not indicate what staff were supposed to do if no results were received after administering the laxatives. A record review revealed Resident #3 was admitted to the facility, on 05/12/09, with diagnoses to include Dementia with Psychotic agitated features and Constipation. A review of the initial Minimum Data Set assessment, dated 05/25/09, revealed the facility assessed the resident as moderately cognitively impaired, which affected decision making ability. The resident was continent of bowel. A review of the Comprehensive Care Plan for Constipation related to decreased mobility and advanced age, dated 11/24/09, revealed a goal for the resident to have a bowel movement at least every third day. A review of the physician's orders, dated 02/2010, revealed orders for Milk of Magnesia liquid 30	F 309	Criteria #4: The CQI indicator for monitoring of the BM Logs shall be completed monthly X 2, then every 6 months as per established CQI calendar under the supervision of the DON. Criteria #5: Target Date	7/23/10

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F 309	<p>Continued From page 12</p> <p>milliliters by mouth once daily as needed for constipation, and 500 ml. Soap Suds Enema once daily, as needed for constipation.</p> <p>A review of the February 2010 BM log and nurse's notes, dated 02/06/10, revealed the resident's last BM was on 02/06/10 after a soap suds enema was administered because the resident complained of abdominal pain. The facility assessed the resident and determined the resident's abdomen was distended and there were hypoactive (decreased) bowels sounds.</p> <p>Further review of the February 2010 BM log revealed the resident had no BM on 02/07/10 and 02/08/10. A review of the nurse's note, dated 02/08/10 at 5:55 AM, revealed the resident complained of abdominal pain. The facility assessed the resident and determined the resident's bowel sounds were hypoactive and a small amount of hard BM was noted when the nurse digitally checked the resident. The nurse's note revealed a soap suds enema was administered with no results obtained.</p> <p>Further review of the February 2010 BM log revealed the resident had no BM on 02/09/10. However, a review of the laxative log sheet revealed Resident #3's name had not been placed on the laxative log sheet in accordance with the facility's protocol. Additionally, a review of the record revealed no documented evidence an assessment was conducted of the resident on 02/09/10 to determine whether the resident was still experiencing abdominal distention, decreased bowels sounds or abdominal pain.</p> <p>A review of the February 2010 log, revealed the resident had no BM on 02/10/10. A review of the</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>24 hour report sheet, dated 02/10/10 on the 7:00 AM-7:00 PM shift, revealed "The resident needed an enema because the resident's abdomen was hard and distended and the resident had decreased bowel sounds". A review of the nurse's notes, dated 02/10/10 at 4:00 PM, revealed a soap suds enema was given with little to no results obtained.</p> <p>Further reviews of the nurse's notes, February 2010 BM log and 24 hour report, revealed Resident #3 continued to have no BM through 02/11/10. A review of the 24 hour report, dated 02/11/10, on 7:00 PM-7:00 AM, revealed there had been no results from the soap suds enema, given on 02/10/10, and the resident's abdomen was described as hard and distended with decreased bowels sounds. Further review revealed no evidence of physician notification. A review of the BM log revealed the resident continued to have no BM.</p> <p>A review the 24 hour report for 02/12/10 on 7:00 AM-7:00 PM and a nurse's note, dated 02/12/10 at 10:45 AM, revealed the physician was faxed related to the "resident's abdomen being distended, decreased bowel sounds and when the resident was checked there was a small, hard BM noted and the staff were unable to remove it." Further record review revealed no evidence the facility received a response to the fax and no evidence the facility made any further attempts to consult with the physician about the resident's condition.</p> <p>A review of the nurse's note, dated 02/12/10 at 9:00 PM, revealed the facility assessed the resident and determined the resident's abdomen was "very distended, the resident grimaced when</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>palpated (examined) and very little bowel sounds could be heard". Further review revealed the facility administered a soap suds enema even though the resident was experiencing abdominal pain with palpation. The nurse's note revealed the enema water would not go into the rectum and the resident began having labored breathing, with the resident's O2 sat. at 56%-62% (critical level). Oxygen was placed on the resident at three liters a minute, the physician was notified and the resident was sent to the emergency room.</p> <p>A review of the hospital x-ray report, dated 02/13/10, revealed the resident had a very distended bladder and it appeared the bladder caused displacement of the bowel loops. A review of the emergency room report, dated 02/13/10, revealed the resident was diagnosed with Urinary Retention and Constipation.</p> <p>A review of the nursing facility's nurse's note, dated 02/13/10 at 4:27 AM, revealed the Emergency Room Nurse had reported to the facility that a large amount of BM was removed from the resident's rectum.</p> <p>An interview with Registered Nurse (RN) #2, on 06/17/10 at 8:55 AM, revealed she was unable to recall the number of days the resident had no BM, when she administered the soap suds enema on 02/12/10. She stated she could not remember if the physician was notified of the resident's condition. She stated she assessed Resident #3, on 02/12/10 and the resident's abdomen was very distended, the resident expressed pain when she palpated the abdomen. She stated she heard very little bowel sounds. She stated she did not notify the physician of the assessment findings.</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>She stated the facility had a constipation protocol, but she did not recall the last time she had read it. She stated when she tried to administer the enema the water would not go into the rectum/colon. She decided the physician would be notified the next morning. The Certified Nurse Aide came to the nurse's desk a few minutes later and made her aware the resident was having difficulty breathing and the resident's O2 sat. was very low.</p> <p>Interviews with RN #1, Licensed Practical Nurse (LPN) #2, LPN #3 and LPN #4 on 06/16/10 at 3:10 PM, 3:15 PM and 3:45 PM and on 06/17/10 at 10:00 AM and 11:00 AM revealed they were aware the resident had not had a BM for six days in February 2010. They stated the resident's name should have been placed on the laxative log sheet each day there was no BM, from 02/09/10 - 02/12/10 and the resident should have been assessed each day. They stated if a medication technician was giving medications, they would notify the nurse so the nurse could assess the resident. They stated the physician should have been notified after the resident had no results from the laxative and enema, to determine if the physician wanted to change the resident's treatment.</p> <p>An interview with the Director of Nursing, on 06/17/10 at 11:00 AM, revealed the nurses should have followed the facility's constipation protocol and placed the resident's name on the laxative list starting on the third day the resident had not had a bowel movement. The resident's name should have been placed on the list each day the resident did not have a BM after that. She stated the resident should have been assessed every day until the resident had a BM. She was unable</p>	F 309			

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F 309	Continued From page 16 to provide an explanation as to why the facility's constipation protocol did not address what the facility was supposed to do when a resident was having abdominal pain prior to administering an enema and when the administration of an enema did not have results. An interview with Resident #3's primary physician, on 06/17/10 at 3:30 PM, revealed he would have expected the nurse to notify him when the resident was experiencing abdominal pain prior to the enemas, when there was no results from the first enema and each time an enema was administered and ineffective after that. Additionally, he revealed the nurse should have notified him when she was unable to get the water to enter the rectum/colon.	F 309	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure one resident (#2), in the selected sample of 10, received the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident #2	F 314	F 314 Treatment to Prevent Pressure Sores Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Criteria #1: Resident #2's heel booties are being applied as per plan of care. His/her heels remain without pressure sores. Criteria #2: An audit of all residents with pressure reducing devices has been completed to ensure devices are in place as per plan of care. Criteria #3: All facility CNA/NA's have received in-service education provided by the DON/ADON on providing care as per each resident's plan of care.

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F 314	Continued From page 17 had a physician's order to wear heel lift boots all the time on 02/22/10. Observations on 06/15/10 and 06/16/10, revealed the staff failed to apply the heel lift boots. Findings include: Resident #2 was admitted to the facility with diagnoses to include Senile Dementia and Anxiety. An interview, on 06/15/10 at 10:55 AM, with the Minimum Data Set Coordinator revealed the resident had a history of a black area on the left heel, which had resolved on 03/19/10. An order was received, on 02/22/10, for the resident to wear heel lift booties at all times. An observation, on 06/15/10 at 10:30 AM, revealed the resident was seated in a recliner and was not wearing heel lift booties. At 11:40 AM, 4:00 PM, and 4:35 PM, the resident was observed in the dining room seated in a wheelchair, without the application of heel lift booties. At 2:43 PM and 3:25 PM, Resident #2 was observed reclined in the recliner, without heel lift booties in place. On 06/16/10 at 8:20 AM, the resident was observed in his/her wheelchair and was not wearing heel lift booties. At 9:30 AM, 10:30 AM, 11:50 AM, 2:08 PM, and 3:00 PM, Resident #2 was observed without heel lift booties applied. An observation of a skin assessment, on 06/16/10, revealed the resident's skin was intact to the heels. An interview, on 06/16/10 at 9:20 AM, with Nursing Assistant (NA) #3 revealed she thought the resident only wore the heel lift boots at night. She stated she had not been instructed to ensure the resident wore the booties all the time.	F 314	Criteria #4: The CQI indicator for the monitoring of care plan implementation shall be utilized monthly X 2 months, then quarterly as per established CQI calendar under the supervision of the DON. Criteria #5: Target Date	7/23/10

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F 314	Continued From page 18 An interview, on 06/16/10 at 8:50 AM, with Licensed Practical Nurse (LPN) #2 revealed she acted as the Charge Nurse for the 7:00 AM until 7:00 PM shift. She stated "If she found a resident without the heel protectors on, she would put them on and inform the CNA providing care to put the items on and not forget". An observation at 9:05 AM, revealed the resident was seated in his/her recliner and was not wearing the heel lift booties. LPN #2 stated "The resident should have the heel lift booties on".	F 314		
F 323 SS=D	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, interview, and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible for two residents (#2 & #6), in the selected sample of 10.	F 323	F 323 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. Criteria #1: Resident #2's chair alarm is being applied as per plan of care. Resident #6 had dycem applied to his wheelchair on 6/16/10 to prevent sliding on wheel chair cushion while lap buddy is in place.	

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F 323	<p>Continued From page 19</p> <p>The facility failed to ensure a personal alarm was used in accordance with the care plan for Resident #2.</p> <p>The facility failed to reassess Resident #6 for the potential risks associated with the use of a lap buddy, after the resident exhibited new behaviors of attempting to scoot down under the lap buddy. Findings include:</p> <p>1. Resident #2 was admitted to the facility with diagnoses, which included Senile Dementia and Anxiety.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/26/10 and the Resident Assessment Protocol (RAP's) dated 09/18/09, revealed the facility identified Resident #2 as confused as a result of advanced Dementia, with impaired safety awareness. The facility assessed the resident as requiring total assistance with all activities of daily living.</p> <p>A review of the Certified Nurse Aide (CNA) care plan, dated 01/28/10 through 06/2010, revealed interventions included the use of a personal safety alarm when the resident was up in a chair, a recliner and in the bed.</p> <p>Observations conducted on 06/15/10 at 10:30 AM, 2:43 PM, and 3:25 PM and on 06/16/10 at 9:05 AM, revealed Resident #2 was reclined in a recliner chair and the personal alarm was not in use.</p> <p>An observation on 06/16/10 at 8:40 AM, revealed Nurse Aide (NA) #3 transferred Resident #2 to a recliner from the wheelchair, and did not apply the personal alarm. NA #3 signed the resident's care</p>	F 323	<p>Criteria #2: An audit of all residents with alarms and/or other fall prevention devices has been completed to ensure devices are in place as per plan of care. A review of all physical restraints currently in use has been completed to determine safe use.</p> <p>Criteria #3: All facility CNA/NA's have received in-service education provided by the DON/ADON on providing care as per each resident's plan of care. In-service education also included reporting unsafe resident activity (such as removing restraints or sliding under a lap buddy/seat belt) to the appropriate charge nurse. LN's have received in-service education provided by the DON/ADON on appropriate actions to be taken when potential unsafe restraint activity is reported to them.</p> <p>Criteria #4: The CQI indicators for the monitoring of care plan implementation and restraint/device use shall be utilized monthly X 2 months, then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date</p>	7/23/10

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F 323	<p>Continued From page 20</p> <p>plan and indicated the signature meant she had completed care for the resident in accordance with the care plan.</p> <p>Interviews with NA #3, on 06/16/10 at 8:40 and 9:20 AM, revealed she was assigned to provide care for Resident #2, on 06/15/10 and 06/16/10. NA #3 stated sometimes staff placed the personal alarm used on the bed, on the recliner, while the resident was in the recliner. However, "The resident was doing better and they were leaving the door open so the staff could see him/her as they were in and out of other resident rooms providing care". NA #3 stated she was aware the alarm was supposed to be applied to the recliner.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 06/16/10 at 8:50 AM, revealed the CNAs provided care according to the resident's care plan. If she observed a resident's alarm not applied in accordance with the care plan, she would apply the alarm and inform the CNA assigned to follow the care plan and apply alarms. On 06/16/10 at 9:05 AM, LPN #2 was observed checking Resident #2, while the resident was seated in the recliner. Resident #2 did not have the alarm applied and LPN #2 stated, "The resident should have an alarm applied to his/her recliner".</p> <p>An interview with the Director of Nursing (DON) on 06/17/10 at 11:00 AM, revealed the Nurse Aides should review the resident's care plan prior to providing care. The Charge Nurses should check the resident's alarm every shift, to ensure proper function. The Nurse Aides also checked the alarms when they transferred the resident from the bed to the chair or vice versa and during provision of any care.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
(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 323	Continued From page 21 A review of the policy entitled "Comprehensive Device Assessment" dated 12/07, revealed the purpose of the assessment was to determine that residents requiring the use of a device/restraint were assessed for the least restrictive device which is appropriate to treat their medical symptoms; and/or to document that: 1) the device/restraint is being used as an enabler and will promote greater functional independence; or 2) used to provide necessary life saving treatment; or 3) device/restraint is used as a positioning device in achieving proper body position, balance, alignment, and preventing contractures; or 4) risk/benefit analysis indicates that restraint/device use is appropriate. The assessment should be completed with each Comprehensive MDS assessment and a quarterly progress note should be completed with each quarterly assessment. A new Comprehensive Device Assessment should be completed when there has been a change in device use. 2. A record review revealed Resident #6 was admitted to the facility with diagnoses, which included Dementia with Behavior Disturbance and Post Traumatic Stress Disorder (PTSD). A review of the quarterly MDS assessment, dated 06/02/10 and a significant change Resident Assessment Protocol (RAP) dated 03/05/10, revealed the facility identified Resident #6 as having poor decision making skills. The facility assessed Resident #6 as requiring extensive to total assistance for activities of daily living. Also, Resident #6 was identified as displaying agitated and combative behaviors and was disruptive with yelling out.	F 323			

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2886 NEW HARTFORD RD OWENSBORO, KY 42303	
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F 323	<p>Continued From page 22</p> <p>A review of the Comprehensive Device Assessment, dated 01/22/10, revealed the facility discontinued the resident's use of a Merrywalker and initiated the resident's use of a wheelchair with an attached lap buddy. The facility's assessment determined the benefit of the use of the lap buddy outweighed the risk associated with the use of the wheelchair and lap buddy. The resident's use of the lap buddy was reviewed, on 03/10/10 and 05/28/10, and determined effective in prevention of injury.</p> <p>An observation, on 06/15/10 at 3:50 PM, revealed Resident #6 was seated in his/her wheelchair and was slapping the top of the lap buddy with open hands. The resident placed his/her arms on the arm rests of the chair and scooted his/her buttocks down in the wheelchair. At 4:17 PM, LPN #1 entered the resident's room and with the assistance of CNA #5, assisted Resident #6 upright in the wheelchair and rolled the resident to the nurse's station. Observation on 06/16/10, at 11:20 AM revealed Resident #6 was in his/her room in the wheelchair with a lap buddy applied across the wheelchair. The resident placed his/her arms on the arm rests and scooted his/her buttocks down in the wheelchair. The resident's left foot was on the wheelchair footrest and his/her right foot was on the floor.</p> <p>An interview, on 06/16/10 at 3:10 PM with NA #1, revealed he had observed Resident #6 start to scoot down in his/her wheelchair, on Monday night (06/14/10) during his shift. He reported the incident to the Charge Nurse on duty, but could not recall the nurse's identity. NA #1 stated the resident displayed behaviors of beating on the lap buddy and crying out.</p>	F 323		

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NAME OF PROMOER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 323	<p>Continued From page 23</p> <p>An interview with Certified Nursing Assistant (CNA) #5, on 06/16/10 at 3:00 PM, revealed the behavior witnessed on 06/15/10 was the first time she observed the resident scoot down in his/her wheelchair.</p> <p>An interview with the MDS Coordinator, on 06/17/10 at 10:50 AM, revealed residents were assessed for assistive devices when applied, quarterly, and with the comprehensive assessment. She had no knowledge Resident #6 was sliding down in the wheelchair. Resident #6 had displayed behaviors and different devices had been used. She stated if there was a problem with the resident sliding down in the wheelchair, they might refer the resident to therapy, but would attempt different interventions, and evaluate effectiveness. She would expect the nurse to report information about the resident sliding, so the use of the device could be reassessed. The resident's behavior was not reported.</p> <p>An interview with the Director of Nursing (DON), on 06/17/10 at 11:00 AM, revealed the behavior exhibited by Resident #6 (sliding down in the wheelchair) was a new behavior and she would expect the Charge Nurse to document the resident's behavior on the 24 hour report, so other shifts could monitor for the behavior. She stated, "I looked at the 24 hour report and there was nothing about the resident sliding down in his/her wheelchair on Monday or Tuesday". If there was a problem with a device documented on the report, then it would be addressed during the morning meeting. Resident #6's newly observed behavior was not reported on the 24 hour report book.</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2010
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 06/15/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "E".	K 000	Disclaimer: 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 062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/15/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25 1999 Edition.</p> <p>The findings include:</p> <p>A tour of the facility, conducted 06/15/10 at 10:30 AM, revealed five sprinkler heads on the canopy to the center court yard were stained with a brown/green substance, ten sprinkler heads in the kitchen were stained with a brown/green substance and one sprinkler head near room #416 was stained with a brown/green substance.</p> <p>An interview with the Maintenance Director, on 06/15/10 at 10:35 AM, revealed he counted on the sprinkler contractors to inform him when there</p>	K 062	<p>K 062 Life Safety Code Standard</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically:</p> <p>Criteria #1-3: The facility automatic sprinkler system was inspected by the facility's contracted provider and a quote of needed replacement heads was provided on 6/25/10. The system has been flushed and the replacement heads have been ordered and are scheduled to be installed by the 7/28/10. Sprinkler heads that are being replaced included those identified during the annual survey: 5 on the center courtyard canopy, 10 in the kitchen, and 1 near room 416.</p> <p>Criteria #4: The Sprinkler system shall be monitored through routine provider inspections and facility CQI program quarterly under the supervision of the Administrator.</p> <p>Criteria #5: Target Date</p>	7/30/10

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

TITLE

Adm

(X6) DATE

7/23/10

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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K 062	Continued From page 1 was a problem with the sprinklers during their quarterly visits. Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			