

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

PRINTED: 04/13/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2010
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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164
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F 000	INITIAL COMMENTS An annual survey was conducted on 03/28/10 through 03/31/10 and a Life Safety code survey was conducted on 03/30/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E". Additionally, an abbreviated survey (KY #14608) was conducted on 03/28-31/10 and was substantiated with deficiencies cited.	F 000	This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.	
F 157 SS=D	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.	F 157	1. The performance of Registered Nurses (RN) #2, #3, and Licensed Practical Nurse (LPN) #5 has been addressed and teaching provided to nurses #2 on 4-16-10, #3 on 4-19-10, and #5 on 4-16-10 to implement the Rapid Response Team (RRT) for a acute change in heart rate, systolic BP, respiratory rate, O2 saturation, conscious state, or urinary output as defined by the RRT protocol and notify the physician of the resident's status, assessment, and recommendations of treatment after conferring with the RRT as outlined by policy. Above actions were conducted by the ADON. 2. All residents of Cal Turner were evaluated for the potential need for rapid response efforts by the DON on 4-19-10. The notification of Physician policy, the RRT policy and criteria have been reviewed. Staff was inserviced on 4-19-10. RRT policy and criteria was distributed to all licensed staff by the Director of Nursing on 4-19-10. 3. The Education and Development department will review the RRT protocol during BLS recertification check off during each staff member's re-certification date. A poster of the RRT criteria was placed in the medication room on 4-20-10 by the education coordinator as a constant reminder to the staff. The staff were	04/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Eric A. Heer* TITLE Administrator (X6) DATE April 22, 2010

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>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to notify one resident's (#19) physician in the selected sample of 21, related to a change in his/her physical status. On 11/26/09 at 2:00 AM, Resident #19 removed his/her Bi-level Positive Air Pressure (Bi-PAP) mask and transferred him/herself to the beside commode. The resident became cyanotic and slumped over. On 11/27/09 at 8:00 AM, the resident complained of chest discomfort. On 11/27/09 at 8:22 PM, the resident complained of chest and back pain. Following each incident the facility staff did not notify the physician of the resident's change. Findings include:</p> <p>Resident #19 was admitted to the facility with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, Respiratory Failure, Obesity, Chronic Renal Failure, and Anxiety.</p> <p>A review of the admission Minimum Data Set (MDS), dated 12/01/09, revealed the resident was independent in his/her decision making.</p> <p>A review of the Notification of Physicians policy, dated 07/30/96 and updated 02/2003, revealed any changes in the resident's status warranted a notification call to all attending and consulting physicians on the case. Note: All physicians</p>	F 157	<p>Continued</p> <p>educated about the posters and their location by the DON on 4-20-10.</p> <p>4. The DON will monitor RRT opportunities and potential failures weekly and report them to the performance improvement committee chairman. The DON will conduct an investigation of any failures and provide performance education and/or counseling based on the event. All residents will be evaluated for potential risk. If any other residents are at risk, the nursing staff will be re-educated. Performance improvement committee meets quarterly to review any opportunities or failures.</p> <p>5. Corrective actions were completed by 4-21-10</p>	

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F 157	<p>Continued From page 2</p> <p>listed on the case must be given a telephone call for communication purposes and perhaps subsequent resident orders and/or patient family instructions.</p> <p>A review of the nurse's notes, dated 11/26/09 at 2:00 AM, revealed the resident removed his/her Bi-PAP mask and nasal cannula, got up to the beside commode, and became cyanotic then slumped over. The facility staff intervened and reapplied the Bi-PAP mask and oxygen. The resident's oxygen saturation came to 85-87%. Following the incident, the resident was assisted back to bed; however, there was no evidence in the record the physician was notified of the incident.</p> <p>An interview, on 03/31/10 at 4:06 PM, with Registered Nurse (RN) #2, revealed she was with the resident when he/she became cyanotic, slumped over, and unresponsive. She stated the resident was refusing to put on the Bi-PAP or oxygen and she explained the importance of wearing the oxygen as well as the Bi-PAP. RN #2 stated, "When the resident slumped over, head back, eyes closed, and was unresponsive, I was trying to take action to get the resident to respond. We put the Bi-PAP back on and increased the oxygen. Within a short time the resident responded and I didn't notify the physician. Looking back, I should have notified the physician."</p> <p>A review of the nurse's notes, dated 11/27/09 at 8:00 AM, revealed the resident complained of chest discomfort. The documentation revealed no evidence the physician was notified of the resident's complaint.</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>An interview, on 03/31/10 at 10:15 AM, with RN #3 revealed the resident complained of chest discomfort to the RN and the RN made the entry in the record. She stated the resident was large in size and had chronic COPD with a lot of breathing problems. RN #3 stated, when they received report on Resident #19 from the local hospital, they were informed the resident had panic episodes. She stated, "I would not notify the physician with complaints of chest discomfort unless the resident was showing signs of distress. Any respiratory distress, abnormal vital signs, and increased confusion, these things I would call the physician about. I've been here 14 years and I kind of pick up on the sign/symptoms if they were cardiac related. His/her problem was anxiety related". She stated she did not notify the physician related to the resident experiencing anxiety and did not think the resident's chest discomfort was related to cardiac problems.</p> <p>A review of the nurse's notes, dated 11/27/09 at 8:22 PM, revealed Resident #19 complained of chest pain and back pain. The record revealed no evidence of the physician being made aware of his/her complaint.</p> <p>An interview, on 03/31/10 at 2:01 PM, with Licensed Practical Nurse (LPN) #5 revealed she was the nurse the resident informed related to his/her complaint. LPN #5 stated she gave the resident Tylenol and a back rub. Afterwards, she stated the resident did not complain of any further chest pain, but he/she informed LPN #5 the pain continued in his/her back. She stated depending on the situation with a complaint of chest pain, would determine if the physician needed to be notified. If the resident complained of pain in the upper abdomen, she might think it was</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>indigestion and give Mylanta. If the resident achieved relief from that and did not have any other symptoms, then she would think the resident was having some indigestion. She would notify the physician if a resident had a change in condition or fever. She stated she could not recall if she was aware the resident complained of chest discomfort earlier in the day. LPN #5 stated, "I would have been more concerned if it was a cardiac problem knowing the resident had complained earlier. It could have been an issue of a gastrointestinal problem, muscular problem, or respiratory problem...knowing that, I would have called the physician at that point." She stated she did not notify the physician because the resident's vital signs were stable, the oxygen saturation was in a normal range, and no diaphoresis was noted.</p> <p>An interview, on 03/31/10 at 2:25 PM, with the Director of Nursing (DON) revealed she would expect the staff to notify the Rapid Response team. She stated the Rapid Response Team consisted of an Advanced Cardiopulmonary Life Support (ACLS) nurse from the emergency room, respiratory therapist, and an acute care nurse with ACLS certification. She stated the physician would also be notified as well.</p> <p>Interviews, on 03/31/10 at 10:40 AM and 1:50 PM, with the resident's primary care physician revealed with the incident on 11/26/09, he would expect the nursing staff to have notified him. The physician stated the staff took action to get the resident to respond, but they should have made him aware of the incident. He stated with complaints of chest discomfort, the nurse should have called to make him aware. Additionally, when the resident complained of chest and back</p>	F 157			

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F 157	Continued From page 5 pain, later on the same day, he stated he would expect the nurse to have called him. "Depending on the resident's vital signs and description of the pain, I may have ordered additional testing and labs. Also, if after the nurse gave the pain medicine and the resident continued to have pain, the nurse should have notified me. Resident #19 was a complicated case and without knowing the nature of the pain, I never hesitate to tell the staff to call me. The resident had no recent myocardial infarcts and I wouldn't have faulted the nurse for calling me. Looking back, with the resident having achy chest pain and not knowing if it was musculoskeletal pain, the nurse should have called before giving the resident Tylenol."	F 157			
F 226 SS=D C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to implement its' policy and procedure related to reporting incidents of suspected abuse immediately and protecting residents from suspected abuse for one resident (#11) in the selected sample of 21. Findings include: A review of the facility's policy and procedure for Suspected Abuse or Neglect, last revised on 03/10, revealed all incidents of suspected abuse should be reported "immediately" to the Administrator, Director of Nursing (DON) or	F 226	1. The performance of RN#1 was addressed on 4-16-10. The performance of LPN #1 was addressed on 4-16-10. The performance of CNA #1 was addressed on 4-18-10. The performance of CNA #3 was addressed on 4-16-10. Teaching was provided to ensure the immediate removal of any person suspected of abuse and timely reporting to protect the residents. These actions were completed by the ADON. 2. The policy for Abuse Recognition and Reporting for all residents of Cal Turner was reviewed for timely recognition and reporting procedures. The facility policy was reviewed, distributed, and an inservice was conducted on 4-19-10 with Cal Turner nursing staff regarding suspected abuse, timely reporting and the proper removal of any alleged threat to protect all residents of Cal Turner. Staff and Residents were interviewed immediately following the incident on 3/23/10 and 3/24/10 to evaluate if other residents were at risk. There were no other incidents of abuse and no further incidents	04/21/10	

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F 226	<p>Continued From page 6</p> <p>designee, Department of Community Based Services and State Licensure and Regulation. The residents would be protected by the "immediate" removal of the individual suspected of abuse or neglect until the investigation was completed.</p> <p>A record review revealed Resident #1 was admitted to the facility with a diagnosis of Traumatic Brain Injury. A review of the Minimum Data Set (MDS) assessment, dated 02/15/10, revealed the resident's cognitive status was moderately impaired and had short term memory loss. The resident was verbally and physically abusive and resisted care. A review of the Comprehensive Care Plan, dated 02/24/10, revealed the resident displayed agitated behavior, loud outbursts of profanity and spastic movements of the left arm.</p> <p>A review of a facility investigative report, dated 03/25/10, revealed Certified Nurse Aide (CNA) #1 reported to RN #1 that while she and CNA #2 and CNA #3 provided incontinent care for Resident #11, she had witnessed CNA #2 "punch" Resident #11 in the thigh with a clinched hand.</p> <p>An interview with CNA #1, on 03/29/10 at 1:58 PM, revealed on 03/23/10 at around 3:00 PM, she entered Resident #11's room and CNA #2 and CNA #3 were changing the resident. She stated as the CNAs started to turn the resident, the resident grabbed CNA #2's arm and as the CNA pulled her arm away, the resident scratched CNA #2. CNA #2 turned around and showed CNA #1 the scratch and a bruise, then turned and punched the resident on the outer left thigh. She stated she immediately left the room and went to the DON's office to report what she saw, but the</p>	F 226	<p>Continued</p> <p>of timely reporting. Consequently, no other residents were at risk. All above actions were conducted by the DON. Skin assessments were also performed on all residents looking for suspicious injuries. These were completed by CNAs and Licensed staff while performing daily skin care. All assessments were completed by 04/21/10.</p> <p>3. Training was provided to all staff on 3-24-10 and will be scheduled again annually beginning 5-10-10 to include timely reporting of any alleged abuse and immediate removal of any individual suspected of alleged abuse. Education will be provided by the Education and Development department coordinator.</p> <p>4. The DON will report any allegations of abuse to the Chairman at the quarterly Performance Improvement meeting following the investigation and timely reporting to the state agency.</p> <p>5. Corrective actions were completed by 4-21-10</p>		

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F 226	<p>Continued From page 7</p> <p>DON was not there. She went back to the nurse's station and asked Registered Nurse (RN) #1 to come to the resident's room with her. When they arrived in the resident's room she began to tell RN #1 what she had witnessed. Before she could finish the whole story, RN #1 asked her to come back to the nurse's station. When they got to the nurse's station, RN #1 told Licensed Practical Nurse (LPN) #1 to go with CNA #1 to examine where CNA #2 had hit the resident. She stated RN #1 then picked up the phone at the nurse's station. She stated she and LPN #1 examined the resident's thigh and there was a red area where she had seen CNA #2's fist hit the resident. She stated she did not ask CNA #2 to leave the resident's room or have her go with her to the nurse. She was unable to provide an explanation as to why she did not make sure CNA #2 was not continuing to provide care for the residents, after CNA #1 saw CNA #2 hit Resident #11.</p> <p>An interview with CNA #3, on 03/30/10 at 10:30 AM, revealed she and CNA #1 and CNA #2 were changing Resident #11 and the resident was striking out during care. She stated this was the resident's normal behavior. She stated when they rolled the resident over, the resident continued to strike out and curse them. She saw the resident hit or punch CNA #2. She stated she then saw CNA #2 take her "closed hand" and hit the resident on the left thigh. She revealed CNA #1 then left the room because therapy knocked on the door to speak to her. When CNA #3 and CNA #2 were finished with the resident, they both left the room and went different directions to care for their assigned residents. CNA #3 revealed she did not report the incident because she was not sure if she was supposed to report it to the</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>DON or the supervisor. CNA #3 was unable to provide an explanation as to why she did not immediately intervene to protect Resident #11.</p> <p>An interview with RN #1, on 03/29/10 at 1:30 PM, revealed on 03/23/10 at a little after 3:00 PM, CNA #1 reported to her she witnessed CNA #2 hit Resident #11 on the left thigh. RN #1 stated she told LPN #1 to go with CNA #1 and examine Resident #11's leg. She revealed she tried to call the Director of Nursing (DON) but was unable to contact her, so she called the Assistant DON (ADON). She stated the ADON told her to send CNA #2 home and get statements from CNA #1 and CNA #3. She sent CNA #2 home then told CNA #1 and CNA #3 to write statements. She revealed she was not sure if she removed CNA #2 from contact with residents as soon as the alleged abuse was reported to her or after calling the DON or ADON.</p> <p>An interview with CNA #2, on 03/30/10 at 3:30 PM, revealed she and CNA #3 were providing care to Resident #11 and the resident was hitting and scratching. She stated this was normal behavior for the resident. She revealed CNA #1 walked into the room. CNA #2 revealed at one point she used her open hand to tap the resident on the leg to get his attention but she never closed her hand and hit the resident. She revealed after finishing the care for Resident #11, she went and got a glass of water and drank it. She then went to do her 3:00 PM round on her residents. She stated she was almost completed with her round when RN #1 took her to the short hall and told her she would have to go home because someone had reported she had hit a resident. She stated she immediately left and it was 3:25 PM when she clocked out that day.</p>	F 226			

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F 226	Continued From page 9 A review of the facility's investigative report form, dated 03/25/10, revealed the facility received a report that CNA #2 had "punched" Resident #11 on the thigh while providing care for the resident. According to the report, the State Licensing Agency was notified on 03/25/10 at 10:30 AM by the DON of the alleged abuse. An interview with the DON, on 03/29/10 at 3:50 AM, revealed she reported the alleged abuse to the State Licensing Agency on 03/25/10. When asked why it was not reported to the State Licensing Agency immediately, she stated the facility had notified DCBS on 03/24/10 and she had tried to notify the State Abuse Registry on 03/25/10, who then told her to call the state office and they told her to notify the State Licensing Agency. She was unable to provide an explanation as to why the State Licensing Agency was not notified until 03/25/10.	F 226			
F 280 SS-D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	1. The plan of care for Resident #1 was revised by the MDS coordinator on 3-31-10. This included monitoring of the oxygen per protocol and monitoring the oxygen saturation. 2. All residents with oxygen orders were identified on 3-31-10 by the MDS Coordinator. The plan of care for these residents were individually examined by the MDS Coordinator on 3-31-10 to ensure that they met the O2 needs of the resident. 3. The policy for oxygen protocol was revised, distributed, and nursing staff were inserviced on 4-19-10 by the DON. The policy included the daily assessment of the liter flow rate on the plan of care by the licensed nurse to ensure oxygen will be maintained at the proper rate with every new order for oxygen.	04/21/10	

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
(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 280	<p>Continued From page 10 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to revise the comprehensive care plan for one resident (#1) in the selected sample of 21 when the facility initiated oxygen therapy for the resident. Findings include:</p> <p>A review of the facility's policy and procedure for care plans, last revised 06/2006, revealed the objective was to provide consistent, continuous care and comprehensive care. The plan of care shall be reviewed by an interdisciplinary team quarterly; "and assessed as appropriate", based on evaluation of the resident progress toward expected goals. Review/revision includes "change of status" and "addition/deletions".</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/07/09 with diagnoses to include Cerebral Vascular Accident and Cardiac Dysrhythmias.</p> <p>Observations of Resident #1 on 03/28/10 at 3:50 PM and 4:50 PM, on 03/29/10 at 8:50 AM, 10:30 AM, 12:25 PM and 1:20 PM and on 03/30/10 at 12:50 PM revealed the resident was receiving oxygen (O2) at one liter a minute (1l./m.) per nasal cannula.</p> <p>A review of the nurse's note, dated 03/10/10 at 7:10 AM, revealed the resident's oxygen</p>	F 280	<p>Continued</p> <p>4. The MDS coordinator will conduct weekly audits to ensure that oxygen protocol for new or changed orders are updated on the comprehensive plan of care. Any variance data will be reported weekly to the DON.</p> <p>5. Corrective actions were completed by 4-21-10</p>		

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 455 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 280	Continued From page 11 saturation rate (O2 sat.) was 87%-88% on room air. O2 was initiated. A review of the Respiratory Therapy Flow Sheet revealed the resident was assessed by respiratory therapy on 03/10/10 at 7:30 AM, and the resident was placed on O2 per nasal cannula at 2 L./minute. A review of the Comprehensive Care Plan, dated 05/18/09 and Nursing Assistant Care Plan dated 03/2010, revealed the facility failed to revise the comprehensive care plan to include oxygen therapy. Interviews with the Director of Nursing (DON), Licensed Practical Nurse (LPN) #1 and LPN #2 on 03/30/10 at 12:50 PM and 1:00 PM and on 03/31/10 at 1:55 PM, revealed there was no revision to the care plan to address oxygen therapy. They were unable to provide an explanation as to why the care plan was not revised.	F 280			
F 328 SS-D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328	1. The plan of care for Resident #1 was revised by the MDS coordinator on 3-31-10. This included monitoring of the oxygen per protocol and monitoring the oxygen saturation. 2. All residents with oxygen orders were identified on 3-31-10 by the MDS Coordinator. The plan of care for these residents were individually examined by the MDS Coordinator on 3-31-10 to ensure that they met the O2 needs of the resident. 3. The policy for oxygen protocol was revised, distributed, and nursing staff were inserviced on 4-19-10 by the DON. The policy included the daily assessment of the liter flow rate on the plan of care by the licensed nurse to ensure oxygen will be maintained at the proper rate with every new order for oxygen. The licensed	04/21/10	

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 328	<p>Continued From page 12</p> <p>Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#1) in the selected sample of 21 received the proper treatment and care related to oxygen therapy. Findings include:</p> <p>A review of the facility's policy and procedure for respiratory therapy, last reviewed on 10/2009, revealed oxygen support would be provided for patients to effectively and safely maintain appropriate oxygen levels. The nurses' responsibility was to check oxygen flow rates periodically to ensure the flow rate was correct. In addition, respiratory therapy would check the concentrators on evening shift to assure that a proper liter flow rate was being used, the unit was free from air flow obstruction, that the filters were clean and humidifiers water level was adequate.</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/07/09 with diagnoses to include Cerebral Vascular Accident and Cardiac Dysrhythmias.</p> <p>A review of a physician's order, dated 03/10/10, revealed oxygen was ordered per protocol. A review of a Nurse's Note, dated 03/10/10 at 7:10 AM, revealed the resident's oxygen saturation rate (O2 sat.) was 87%-88% on room air and O2 was initiated. A review of the Respiratory Therapy Flow Sheet, revealed the resident was assessed by respiratory therapy, on 03/10/10 at 7:30 AM, and determined the resident needed to be on O2 per nasal cannula at 2 liters a minute (2 L./m.). However, observations of Resident #1 on 03/28/10 at 3:50 PM and 4:50 PM, on 03/29/10 at 8:50 AM, 10:30 AM and 12:25 PM and on 03/30/10 at 10:20 AM, revealed Resident #1 was receiving O2 at 1 L./m. per nasal cannula.</p>	F 328	<p>Continued</p> <p>nurse will document the flow rate on the M.A.R. daily. All actions above were conducted by the DON.</p> <p>4. The respiratory therapist and licensed staff will report off to the nurse responsible for the resident's care every evening that oxygen flow rates and equipment checks were completed and correct per oxygen protocol for every resident receiving oxygen therapy. Any variance data will be reported immediately to the DON who will report it quarterly to the performance improvement chairman and committee.</p> <p>5. Corrective actions were completed by 4-21-10</p>		

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSDALE, KY 42164		
(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 328	Continued From page 13 A review of the Comprehensive Care Plan, dated 05/18/09 and Nursing Assistant Care Plan dated 03/2010, revealed the facility failed to revise the care plan to address the resident's need of oxygen therapy or the amount of oxygen the resident was supposed to receive. A review of the March Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed there were no interventions to indicate the amount of oxygen the resident was supposed to receive or that nursing was checking to ensure the oxygen was at the appropriate rate. Interviews with the Director of Nursing (DON), Licensed Practical Nurse (LPN) #1 and LPN #2 on 03/30/10 at 12:50 PM and 1:00 PM and on 03/31/10 at 1:55 PM revealed there was no revision to the care plan to address Resident #1's need for oxygen therapy. They were unable to provide an explanation as to why the care plan was not revised. They stated the amount of oxygen the resident was supposed to receive or oxygen rate checks were not indicated on the MAR or TAR to ensure a resident's oxygen was flowing at the appropriate rate. They revealed nursing did not check oxygen flow rates or adjust the rates of oxygen for residents unless a resident was showing symptoms of respiratory distress. They were unable to provide an explanation as to why Resident #1's oxygen was running at 1 L/m. for three days. An interview with the Respiratory Therapist, on 03/21/10 at 3:25 PM, revealed once a resident was placed on oxygen, a respiratory therapist would make rounds nightly to ensure the machine was working properly, the filter was clean and not blocked and O2 was running at the appropriate	F 328			

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164
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F 328	Continued From page 14 rate. She stated Resident #1's oxygen was supposed to be running at 2 L./m. She was unable to provide an explanation as to why Resident #1's oxygen had been running at 1 L./m for three days.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure that it was free of medication error rates of 5% or greater. During the survey, a total of 42 opportunities were observed with four (4) medication errors, which affected three residents (#22, #24, #25), not in the selected sample. The facility's medication error rate was 9.5%. Findings include: 1. Resident #22 was admitted with diagnoses to include Status Post Cerebral Vascular Accident, Diabetes Mellitus Type II, and Hypertension. Observation of a medication pass, on 03/29/10 at 8:55 AM, revealed Licensed Practical Nurse (LPN) #3 crushed one Mucinex ER (extended release) 600 milligram (mg) tablet and a Glipizide ER 10 mg tablet, then placed them in applesauce and administered them to the resident. A review of the physician's orders, dated 03/01/10, revealed an order for Mucinex ER 600 mg tablet by mouth two times daily and Glipizide	F 332	1. The performance of LPN #3 was addressed on 4-19-10. The performance of LPN #4 was addressed on 4-10-10. The performance of LPN #6 was addressed on 4-20-10. This included education on how to administer medications and call the physician as outlined in the Medication Administration policy. These actions were completed by the ADON. 2. All residents who receive medication administration were identified by the DON on 4-19-10. The Medication Administration policy was also reviewed on 4-19-10 by the DON to ensure it was accurate. 3. The policy was distributed and an inservice was conducted on 04/19/10 with all staff who administers medications regarding the policy and administration of medications in accordance with written orders of the prescriber. All actions above were completed by the DON. 4. Any nurse that identifies a variance from the administration of medication as defined by the policy will report it immediately to the DON or ADON. Rates of variances/errors will be monitored monthly by the medication safety committee for necessary remedies. 5. Corrective actions were completed by 4-21-10	04/21/10

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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 332	<p>Continued From page 15</p> <p>ER 10 mg table by mouth two times a day with meals. Both orders revealed instructions "do not crush".</p> <p>An interview, on 03/29/10 at 1:25 PM, with LPN #3 revealed she noticed the Mucinex was not to be crushed, but felt nervous about being watched during a medication pass. She stated she did not know what to do after realizing the Mucinex was not to be crushed; however, she stated she was not aware the Glipizide ER could not be crushed.</p> <p>2. Resident #24 was admitted with diagnoses to include Hypertension, History of Cerebral Vascular Accident, and Lumbar Spinal Stenosis.</p> <p>Observation of a medication pass, on 03/28/10 at 5:25 PM, revealed LPN #4 administered Hydralazine 25 mg tablet.</p> <p>A review of the physician's order, dated 03/01/10, revealed an order for Hydralazine 25 mg tablet by mouth four times a day (6:00 AM, 11:00 AM, 4:00 PM, and 9:00 PM).</p> <p>An interview, on 03/30/10 at 1:10 PM, with LPN #4 revealed she was helping the other nurse. She stated she administered the medication but did not realize the medication was late. Additionally, she stated she overlooked that the Geodon was to be administered with food.</p> <p>3. Resident #25 was admitted with diagnoses to include Depression, Diabetes Mellitus, and Hypertensive Heart Disease.</p> <p>Observation of a medication pass, on 03/28/10 at 4:31 PM, revealed LPN #6 administered Gabapentin 300 mg capsule.</p>	F 332			

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F 332	<p>Continued From page 16</p> <p>A review of the physician's order, dated 03/01/10, revealed an order for Gabapentin 300 mg capsule by mouth two times a day (8:30 AM and 6:00 PM).</p> <p>An interview with the Director of Nursing (DON), on 03/31/10 at 2:25 PM, revealed the medication should not have been given at the time it was administered. She stated if the resident was "going on an outing", then adjustments could be made for the administration of the medication. She did not know why the nurse gave the medication so early. Attempts to interview LPN #6, who administered the medication, were unsuccessful.</p> <p>An interview, on 03/31/10 at 2:25 PM, with the DON revealed the staff have an hour before or after the time to administer the medication. She stated she would expect the staff to administer the medication as ordered. If the nurse administered the medication other than the time ordered by the physician, she should notify the physician as well.</p> <p>A review of the facility's policy/procedure for "Medication Administration General Guidelines," dated 10/2007, revealed "medications are administered in accordance with written orders of the prescriber."</p>	F 332			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2010
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NAME OF PROVIDER OR SUPPLIER CAL TURNER EXTENDED CARE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164
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K 000	INITIAL COMMENTS	K 000	This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.	
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 03/30/10, 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 to include:</p> <p>A tour of the facility conducted 03/30/10 at 10:30 AM, revealed six sprinkler heads in the kitchen and two sprinkler heads in the laundry were stained with a black and brown substance.</p> <p>An interview with the Maintenance Director on 03/30/10 at 10:35 AM, revealed he was not aware of the build-up of corrosion on the sprinkler heads.</p> <p>Reference to:</p>	K 062	<p>1,2. No residents were identified to be affected by this deficiency.</p> <p>3. All of the sprinkler heads in the kitchen are being replaced by Eagle Fire Protection. This was completed 4-21-10. The sprinkler heads in the laundry were cleaned on 3-31-10 by Engineering staff. The preventive maintenance notifications of cleaning and checking sprinkler heads has been assigned to the Facilities Manager quarterly. He will assign these tasks to the maintenance staff and follow up to ensure they are completed successfully by the end of the respective month. He will indicate this has been successfully completed by documenting completion in our ISIS Pro Preventive Maintenance program.</p>	04/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE May 11, 2010

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 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	Continued 4. The preventive maintenance schedule has been updated by our Engineering Manager on 04/21/10 for cleaning sprinkler heads using our ISIS Pro preventive maintenance program. The schedule frequency has been increased from semiannual to quarterly cleaning of sprinkler heads. The quarterly cleaning schedule started 4-1-10. 5. All corrections will be completed by 4-21-10.	

