

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

PRINTED: 05/17/2011
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 05/04/2011
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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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(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
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F 000	INITIAL COMMENTS An annual survey was conducted on 05/02/11 through 05/04/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "E".	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of facility policy and interviews, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one resident (#13), in the selected sample of 21. Observations of Resident #13 revealed a bed alarm and a chair alarm were not utilized by the facility, as indicated on the plan of care. Findings include: A review of the policy "Care Plans," revised 06/06, revealed the objective of the care plans were to provide consistent, continuous, and comprehensive care. A record review revealed Resident #13 was admitted to the facility on 04/22/11 with diagnoses to include Mental Status Change and Alzheimer's	F 282	F282 This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Extended Care Pavilion and is not an admission that the deficiencies cited are correct. 1. The bed and chair alarms were checked and in place for resident #13 upon notification of the deficient practice by the charge nurse on 5-4-11. Resident #13 was educated and agreed to bed and chair alarm use as an intervention for fall prevention on 5-4-11 by the Director of Nursing and a licensed nurse. Education was conducted with the resident on the purpose of alarms and the hazards of falls by the Director of Nursing on 5-4-11. <i>The following revisions to the Care Plan were made by the DON:</i> <i>A. Ongoing education to the resident on the purpose of alarms and hazards of falls (completed 05/04/11).</i> <i>B. A different bed alarm was placed with automatic verbal cues for safety (completed 05/17/11).</i> <i>C. Daily audit of alarm placement, function, effectiveness of deterring resident #13 from getting up without assistance (completed 05/21/11).</i> The plan of care for resident #13 and the nursing assistant plan of care were reviewed with the clinical staff by the Director of Nursing	5/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE June 06, 2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1 Type Dementia.</p> <p>A review of the "Nursing Admission Assessment," dated 04/22/11, revealed the resident was assessed to be a moderate risk for falls.</p> <p>A review of the "Falls/Safety Risk" care plan, dated 04/22/11, revealed the resident was to have an alarm on the bed and the wheelchair.</p> <p>A review of the "Nursing Assistant Care Plan," undated, revealed a bed alarm and a chair alarm were indicated to be safety devices for Resident #13.</p> <p>Observations of Resident #13, on 05/02/11 at 12:45 PM and 3:40 PM, revealed the resident was in his/her bed with a sensor alarm box attached to the right side rail. The sensor alarm pad was laying on the right side of the floor, and not in the bed. The alarm was not sounding. Observations, on 05/03/11 at 8:00 AM and 9:00 AM, and on 05/04/11 at 10:20 AM, revealed the resident was up in his/her wheelchair without an alarm in place.</p> <p>An interview with the Certified Nurse Aide (CNA) #4, on 05/04/11 at 9:35 AM, revealed she worked on 05/03/11 as the "shower aide" when she assisted Resident #13 with his/her bath. She revealed the resident did not have an alarm on the wheelchair on 05/02/11. Additionally, she revealed an assignment sheet was not given to her which indicated what type of care each resident needed. Her assignment sheet listed the names of residents she was expected to assist with a shower.</p>	F 282	<p>CONTINUED (5-16-11 and 5-20-11).</p> <p>2. The comprehensive plan of care and the nursing assistant care plans for all residents were reviewed on 5-16-11 by the charge nurse, director of nursing and assistant director of nursing for accuracy of bed and chair alarm use by the residents in the facility. The charge nurse, director of nursing and assistant director of nursing checked each resident to ensure the care plans were reviewed and the alarms were operational in accordance with how they were care planned on 5-16-11.</p> <p>3. Inservice training was conducted on 5-16-11 and 5-20-11 by the Director of Nursing with the clinical staff to ensure that clinical staff are aware of the location of the comprehensive plan of care, nursing assistant plan of care, the purpose of the care planning process, and the revision process for the plan of care and nursing assistant plan of care, the maintenance schedule for the bed and chair alarms, how to ensure the alarms are on and functioning according to the plan of care, and the process for documenting the alarm use.</p> <p>4. Residents who were assessed to require a bed and chair alarm by a licensed nurse are monitored every shift by licensed staff or a medication tech with the documentation for placement and functioning order of the alarm on the MAR. This process was completed on 5-21-11 by the charge nurse and Director of Nursing. The batteries for the alarms are changed by licensed staff or a medication tech every two weeks with documentation on the MAR. This process was in place on 5-21-11 by the charge nurse and Director of Nursing. <i>An audit of all alarms will be conducted every shift by licensed staff or medication tech and</i></p>	
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F 282	Continued From page 2 An interview with the Charge Nurse, on 05/04/11 at 2:50 PM, revealed Resident #13 had periods of confusion, and should have an alarm on the bed and the wheelchair for safety. She revealed the CNAs signed the nursing assistant care plans, therefore, they would be responsible to ensure the appropriate safety devices were placed and functioned as indicated on the plan of care. An interview with the Director of Nursing (DON), on 05/04/11 at 4:15 PM, revealed the nursing assistant care plans were made available for the CNAs, and she expected them to follow each resident's plan of care.	F 282	CONTINUED <i>recorded on the medication administration record. The results of this audit will be gathered monthly and reported quarterly to the Performance Improvement Committee by the Assistant Director of Nursing.</i> <i>Q.A. members include:</i> <i>Medical Director, P.I. Coordinator, ESD/Engineering, Physical Therapy Manager, Wound Care Nurse, Activity Director, ADON Social Worker, DON, Administrator, and MDS coordinator.</i> 5. Corrective actions were completed by 5-23-11.	
F 323 SS=E	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 observations, record reviews, review of facility policy and interviews, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for two residents (#13 and #14), in the selected sample of 21, related to the failure to ensure bed alarms and wheelchair alarms were in place and	F 323	This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Extended Care Pavilion and is not an admission that the deficiencies cited are correct. 1. Resident's #13 and #14 were assessed by the charge nurse on 5-4-11 for placement and function of their safety alarms. The alarms for resident #13 have ongoing monitoring for placement every shift by a licensed nurse or medication tech with documentation of the monitoring on the MAR. Resident #14 was placed on increased monitoring (05/04/11) by the DON. A certified nursing assistant monitors the resident when out of bed until a new self-release lap belt was available. The risks vs. benefits for the use of a self-releasing lap belt and the evaluation of the resident's ability to self-release the lap belt were completed (05/05/11) by the MDS coordinator, PTA and the Director of Nursing. A new self-releasing lap belt was placed on Resident #14 on 5-5-11 following the completion of a device	5/23/11

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F 323	Continued From page 3 functioning. Additionally, four residents (#23, #24, #25, #26), not in the selected sample, were not assessed for the safe use of low air loss mattresses, (set on alternating pressure), prior to the use of the assistive devices. On 12/15/10, 01/29/11 and 02/07/11, Resident #23 fell out of bed and experienced three unwitnessed falls. On 01/29/11, the resident fell out of the bed and was sent to the emergency room for an evaluation, due to the complaint of right hip pain, but did not result in a fracture. Resident #24 was not assessed for the safe use of a low air loss mattress. On 02/04/11 and 02/08/11, the resident was found lying on the floor by his/her bed. Resident #25, who utilized an air mattress, was found on the floor on 01/19/11 by the bed and there was no assessment for the safe use of the air mattress. On 04/16/10, Resident #26 sustained an unwitnessed fall from a low air loss mattress. Findings include: 1. A review of the policy "Resident Fall Risk Assessment and Intervention," revised 01/11, revealed an objective to ensure each resident received adequate assistance devices to prevent falls. Assistive devices, including bed alarms and chair alarms, would be reinforced as an intervention for residents considered at a moderate risk for falls. The policy further revealed CNAs were responsible for ensuring assistive devices were in proper working order prior to placement. All malfunctioning equipment should be reported immediately to the CNA supervisor. Engineering staff would then be notified. A record review revealed Resident #13 was	F 323	CONTINUED assessment by the MDS RN, Director of Nursing, and PTA. The possible risks of the belt were considered as well as the possible benefits of the self-releasing belt. <i>Education with resident #14 and next of kin for the lap belt's risks vs. benefits for use was documented (05/05/11) on the Comprehensive Device Assessment by the MDS coordinator, PTA and the Director of Nursing.</i> Resident #14 demonstrated how to release the belt. Residents #23, #24, #25 and #26 each were assessed on 5-5-11 by the Director of Nursing and MDS RN with individual consideration for the possible risks and possible benefits for use of the low air loss mattress in the static or alternating mode. Education was conducted with the appropriate resident and next of kin/guardian. The documentation of the assessment and education was by the MDS RN and Director of Nursing on 5-5-11 on the device assessment. The comprehensive plan of care and the nursing assistant care plans for all residents were reviewed on 5-5-11 by the charge nurse, director of nursing and assistant director of nursing for accuracy of bed and chair alarms used by the residents in the facility. The charge nurse, director of nursing and a licensed nurse checked each resident's personal alarm on 5-5-11 to ensure they were connected, operational, and functioning in accordance with the fall risk assessment and facility plan of care. <i>The risks vs. benefits for the use of the air mattresses on all residents with low air loss mattresses were assessed (05/05/11) by a licensed nurse, D.O.N., and MDS RN. The assessments were documented (05/05/11) on the comprehensive device assessment by a licensed nurse, D.O.N.,</i>	
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F 323	<p>Continued From page 4</p> <p>admitted to the facility on 04/22/11 with diagnoses to include Mental Status Change and Alzheimer's Type Dementia.</p> <p>A review of the Initial Nursing Assessment, dated 04/22/11, revealed the facility assessed the resident to be a moderate risk for falls.</p> <p>A review of the "Activities of Daily Living (ADL) Functional/Rehab Potential" care plan, dated 04/22/11, revealed the resident required assistance of one staff for ambulation and transfers.</p> <p>A review of the "Falls/Safety Risk" care plan, dated 04/22/11, revealed the resident was to have a bed alarm and a wheelchair alarm.</p> <p>Observations of Resident #13, on 05/02/11 at 12:45 PM and 3:40 PM, revealed the resident was in bed with a sensor alarm box attached to the right side rail. The sensor alarm pad was laying on the right side of the floor, instead of being on the bed. The alarm did not sound. Observations, on 05/03/11 at 8:00 AM and 9:00 AM, and on 05/04/11 at 10:20 AM, revealed the resident was up in the wheelchair without an alarm.</p> <p>An interview with Certified Nurse Aide (CNA) #2, on 05/04/11 at 12:00 PM, revealed she was responsible for the resident's care on 05/02/11, from 7:00 AM to 3:30 PM. She stated that she should have ensured the bed alarm was placed correctly on the bed. She revealed the resident was "new," and she was not aware the resident was supposed to have a bed alarm.</p>	F 323	<p>CONTINUED</p> <p><i>and MDS RN.</i></p> <p>2. All residents that have been care planned by the licensed staff to require a bed and chair alarm are monitored every shift by licensed staff or medication tech with documentation for placement and functioning order on the MAR. The batteries for the alarm are changed by the licensed staff or medication tech every two weeks with documentation on the MAR. This process was in place on 5-21-11 by the charge nurse and Director of Nursing.</p> <p>3. <i>The fall prevention form was updated (05/21/11) by the Director of Nursing. The Mattresses were assessed (05/05/11) by the D. O.N, MDS RN and a licensed nurse. An inservice was conducted on 5-5-11 by the Director of Nursing with the clinical staff to ensure that clinical staff are aware of the following:</i></p> <ul style="list-style-type: none"> a. The location of the comprehensive plan of care and nursing assistant plan of care containing personal alarm and mattress instructions. b. Process for developing and revising the plan of care and nursing assistant plan of care. c. The maintenance schedule for the bed and chair alarms. d. To ensure the alarms are connected, and operational according to the individual plan of care and fall risk assessment. e. Documentation of alarm function and placement. 	

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F 323	<p>Continued From page 5</p> <p>An interview with CNA #3, on 05/04/11 at 11:00 AM, revealed she was responsible for the resident's care on 05/02/11, after 3:30 PM. She revealed the resident took the bed alarm off at times, but it was her responsibility to ensure the alarm was placed correctly on the bed.</p> <p>An interview with CNA #4, on 05/04/11 at 9:35 AM, revealed she assisted Resident #13 with a shower on 05/03/11, but there was no alarm in place on the resident's wheelchair.</p> <p>Interviews with CNA #5 and #6, on 05/04/11 at 9:45 AM and 9:55 AM, revealed they were not aware Resident #13 was supposed to have an alarm on his/her wheelchair.</p> <p>An interview with the Charge Nurse, on 05/04/11 at 2:50 PM, revealed Resident #13 displayed periods of confusion and was not able to safely transfer or ambulate independently. An alarm was placed on the resident's wheelchair and bed on admission. The alarms were indicated on the resident's plan of care, and the CNAs were responsible for placement of the alarms.</p> <p>2. A record review revealed Resident #14 was admitted to the facility on 08/17/10 with a diagnosis to include Decreased Mental Status.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 02/01/11, revealed the facility assessed the resident to be moderately cognitively impaired and required limited assistance with ambulation and transfer.</p> <p>A review of the "Resident Fall Tracking Log", dated 04/06/11, revealed the facility assessed the</p>	F 323	<p>CONTINUED</p> <p>f. The fall risk assessment protocol and procedure for items that require a device assessment before implementation including but not limited to a self-releasing belt and low air loss mattress with alternating modes.</p> <p>g. How to complete a work order for any damaged or non-functioning equipment. Non-functioning equipment will be replaced immediately with the same or equally effective fall prevention intervention.</p> <p>h. The cautions and hazards associated with using low air loss mattresses according to the user manual of Synergy Air Elite Low Air loss Alternating Therapy system from Hill-Rom.</p> <p>i. Instillation, removal, and cleaning of the low air loss mattress.</p> <p>j. Instructions for use of the low air loss mattress including but not limited to the Alternating therapy mode and timing cycle.</p> <p>k. Instructions if the facility had an interruption in power.</p> <p>The Fall Prevention Protocol form was updated on 5-5-11 stating that low air loss mattresses used in the facility will be assessed considering the risk of hazards compared to the benefits for use and re-assessed quarterly and with any significant change. All residents that have been care planned by the licensed staff to require a bed and chair alarm are monitored every shift by licensed staff or medication tech with documentation for placement and functioning order on the MAR. The batteries for the alarm are changed by the licensed staff or medication tech every two weeks with documentation on the MAR. This process was in place on 5-21-11 by the charge nurse and Director of Nursing.</p>	
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F 323	<p>Continued From page 6</p> <p>resident to be a moderate risk for falls. The summary on the tracking log revealed Resident #14 sustained a fall from the wheelchair, on 04/06/11, and the seatbelt alarm did not sound.</p> <p>A review of the care plan "Potential for Injury," dated 08/31/10, revealed an intervention was added, on 04/06/11, to ensure the resident's alarm functioned properly.</p> <p>An observation, on 05/03/11 at 4:10 PM, revealed Resident #14 had a self-releasing seatbelt alarm on his/her wheelchair. Licensed Practical Nurse (LPN) #5 asked the resident to remove the seatbelt, in an effort to ensure the resident could release the seatbelt on command. The resident removed the seatbelt, but the alarm did not sound. The seatbelt was placed back on the resident, and a repeat demonstration was performed. The alarm did not sound on the second attempt. The cord to the alarm connected to the device like a "telephone jack." The cord was secured to the device with "tape." Further observation of the cord revealed it would not stay connected to the device without the tape.</p> <p>An interview with LPN #5, on 05/04/11 at 9:00 AM, revealed the cord to the resident's alarm was "taped" in an effort to keep the device working properly, but the cord pulled away from the connector. She revealed "everybody" was responsible to ensure the alarms functioned, but it was not documented in the record.</p> <p>An interview with CNA #5, on 05/04/11 at 9:45 AM, revealed the CNAs ensured the alarms functioned. She revealed she did not document whenever an alarm was checked, and did not</p>	F 323	<p>CONTINUED</p> <p>4. Corrective actions will be monitored through weekly random audits conducted (by DON, ADON, or Charge Nurse) to ensure that residents who have devices also have been assessed with the risks vs. benefits for use of devices. Supportive documentation for risks vs. benefits will be placed on the comprehensive device assessment by licensed staff. The results of the random audits are reported by DON quarterly to the Performance Improvement Committee.</p> <p>Residents are assessed with individual consideration for the possible risks and possible benefits for use of the low air loss mattress in the static or alternating mode by two licensed nurses before use. In addition, residents who are currently using low air loss mattresses will be re-assessed minimally by two licensed nurses quarterly, and with any significant change in condition. The assessment of low air loss mattresses will be documented by two licensed nurses on the device assessment.</p> <p>5. Corrective actions were completed by 5-23-11.</p>	

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F 323	<p>Continued From page 7</p> <p>know how she was supposed to ensure each resident's alarm functioned properly.</p> <p>Interviews with CNA #3, #6, and #7, on 05/04/11 at 9:55 AM, 10:00 AM, and 11:00 AM, revealed all staff were responsible for ensuring residents' alarms functioned properly, but they did not document when the alarms were checked.</p> <p>An interview with the Charge Nurse, on 05/04/11 at 2:50 PM, revealed she expected the CNAs to ensure an alarm functioned properly prior to placement of the alarm. She revealed the "clip" that connected to Resident #14's seatbelt alarm was broken. She expected the staff to replace the broken alarm.</p> <p>An interview with the Director of Nursing (DON), on 05/04/11 at 4:15 PM, revealed CNAs were supposed to ensure placement of the alarms. Resident #14 had pulled on the cord of the seatbelt alarm. She revealed the alarm was "re-aligned" and worked properly, without "tape," on the morning of 05/02/11. She expected nursing staff to notify engineering regarding the broken alarm, rather than utilizing "tape" to fix it.</p> <p>3. A review of the facility's policy and procedure, "Resident Fall Risk Assessment and Intervention," dated October 1998 and revised January 2011, revealed the residents were to receive adequate supervision and assistive devices to prevent falls and included recommendations of interventions, in case of falls. The Fall Prevention Protocol did not address the use of a low air flow mattress or interventions used in case of a fall from these mattresses.</p>	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 8</p> <p>Manufacturer Guidelines and Instructions for the safe use of alternating air mattresses was not available on-site at the facility.</p> <p>A record review revealed Resident #23 was admitted to the facility on 05/29/10 with diagnoses to include Obesity, Alzheimer's Disease and a History of a Cerebral Vascular Accident in 2004 with resulting Right Upper Extremity Hemiparesis.</p> <p>A review of the quarterly MDS, dated 02/14/11, revealed the resident was assessed to be severely cognitively impaired and required the extensive assistance of two staff members for bed mobility.</p> <p>Reviews of the Initial Comprehensive Device Assessment, dated 06/10/10; the Comprehensive Side Rail Assessment, dated 05/29/10; the Quarterly Physical Device Review, dated 09/08/10; and the Comprehensive Device Assessment, dated 06/09/10, revealed no mention of the low air loss mattress.</p> <p>A review of the Comprehensive Care Plan, dated 06/25/10 and last updated on 03/08/11, revealed potential for injury related to falls due to short term memory loss and weakness, interventions which included the use of wedges to both sides of the mattress to define the bed boundaries. The wedges were implemented on 12/5/10 and a mat at the bedside to prevent injury was implemented on 01/29/11. A bed alarm was changed to a pressure alarm connected to the call light system on 02/07/11. The resident was to be assisted out of the bed and to the day area while awake, which was implemented on 02/08/11.</p>	F 323			

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

PRINTED: 05/17/2011
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 05/04/2011
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F 323	<p>Continued From page 9</p> <p>A review of the Summary of the Investigative Findings for Resident #23, dated 12/05/10, revealed the alarm sounded and the resident was found lying bedside the bed, on bedside mats. No injury was noted and the resident stated he/she attempted to roll over in the bed. The resident was prescribed a low air loss mattress due to a healing Stage III pressure sore to the heel. As a result of the investigation, foam wedges were to be utilized to prevent the resident from rolling out of the bed and to provide bed boundaries.</p> <p>An interview with LPN #4, on 05/04/11 at 1:15 PM and 1:45 PM, revealed the LPN was responsible for ordering the low air loss mattresses for the residents and stated there was no formal assessment for the risk and benefits of utilizing the mattresses. The LPN stated she assessed the resident's cognitive status, mobility, and determined if the resident was someone who could sit up on the side of the bed prior to implementation of the device. She stated in order for the resident to receive one of these mattresses, the resident must have a developing pressure area.</p> <p>An interview with the Charge Nurse, on 05/04/11 at 5:05 PM, 5:25 PM and 5:42 PM, revealed the investigation of the falls did not identify the causative factors for the falls, outside of the resident trying to get out of bed. The interventions did not protect the resident from further falls.</p> <p>4. A record review reveled Resident #24 was admitted to the facility on 12/02/08 with diagnoses to included Dementia, Diabetes Mellitus, Hypertension and Anorexia.</p>	F 323			

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

PRINTED: 05/17/2011
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 05/04/2011
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F 323	<p>Continued From page 10</p> <p>A readmission MDS assessment, dated 01/13/11, revealed the facility assessed Resident #24 to be cognitively impaired, unable to ambulate, and required assistance for bed mobility and transfers.</p> <p>A review of a nurse's note, dated 02/04/11 at 11:25 PM, revealed the resident was found sitting on his/her knees in the floor beside his/her bed. No injury was identified and the physician and family were notified. Safety mats were implemented.</p> <p>Further review revealed there was no documented evidence of an assessment for the safe use of the air mattress.</p> <p>5. A closed record review revealed Resident #25 was admitted to the facility on 01/11/11 with diagnoses to include Acute Renal Failure, Hypernatremia, Anxiety and Depression and was on comfort measures.</p> <p>An admission MDS assessment, dated 02/24/11, revealed Resident #25 was assessed to be cognitively impaired, required assistance with bed mobility and transfers and was not ambulatory. The resident had care plan interventions which included a bed alarm and safety mats.</p> <p>A review of a fall tracking log entry revealed he/she was found on the floor on 01/17/11 at 1:30 AM. No injury was identified. The facility investigative report, dated 01/18/11, revealed the resident had an air mattress that had tendency to "give" with the resident when he/she turned in the bed. A wedge was initiated to position and to</p>	F 323			

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

PRINTED: 05/17/2011
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 05/04/2011
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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 323	<p>Continued From page 11 define boundaries on 01/17/11.</p> <p>Further review of a nurse's note, dated 01/19/11 at 10:50 PM, revealed the resident was found lying on the floor and the bed alarm did not sound. No injury was identified and the resident told staff she scooted off the bed and across the floor because he/she wanted to be with his/her babies.</p> <p>There was no documented evidence of an assessment for the safe use of the air mattress.</p> <p>An interview with LPN #5, on 05/04/11 at 9:00 AM, revealed "everybody" was responsible to ensure alarms functioned properly, however, this was not documented in the record.</p> <p>An interview with LPN #4, on 05/04/11 at 1:15 PM and 1:45 PM, revealed she was responsible for ordering the low air loss mattresses for the residents and stated there was no formal assessment for the risk and benefits of utilizing the mattresses.</p> <p>6. A closed record review revealed Resident #26 was admitted to the facility on 04/08/10 with diagnoses to include Arthritis, Anxiety and Dementia.</p> <p>A review of the significant change MDS, dated 10/07/10, revealed the facility assessed Resident #26 to be severely cognitively impaired and required extensive assistance with bed mobility. The MDS further revealed total assistance was required for transfers. The resident's range of motion was impaired on both sides of the lower extremities.</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 12 A review of the "Resident Fall Tracking Log," dated 04/16/10, revealed the facility assessed the resident to be a moderate risk for falls. The tracking log revealed the resident sustained a fall from the bed on 04/16/10 at 6:55 AM. The fall was unwitnessed, and the resident was unable to provide information regarding the fall. An interview with LPN #1, on 05/04/11 at 6:10 PM, revealed she assessed Resident #26 after the fall, on 04/16/10. She revealed the resident was on a low air flow mattress, with half side rails raised on both sides of the bed. She revealed the resident was not assessed for the safe use of the low air flow mattress prior to, or after the fall because "it was no different than any other mattress."	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F425 This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Extended Care Pavilion and is not an admission that the deficiencies cited are correct. 1. The medication identified for resident #22 was removed upon identification of deficient practice on 5-4-11. 2. An audit of medications for all residents was completed 5-5-11 by four licensed nurses and no other medications were identified with expired dates. 3. An audit form was developed and inserviced by the Director of Nursing on 5-16-11 and 5-20-11 on the process for immediate removal of expired medications during monthly scheduled audits. Licensed nurses are responsible the monthly audits and the charge nurse will be responsible for making the audit assignments and monitoring of the audit monthly. The audit process began on 5-18-11 by the charge nurse.	5/23/11	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 425	<p>Continued From page 13 services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interviews, it was determined the facility failed to provide pharmaceutical services to meet the needs of one resident (#22), not in the selected sample, related to expired narcotic medications.</p> <p>Findings include:</p> <p>A review of the policy "Storage of Medications in the Pharmacy", revised 02/11, revealed outdated drugs should be removed from general storage areas and placed in separate designated areas until disposal could be arranged.</p> <p>An observation of the medication cart, on 05/04/11 at 2:00 PM, revealed Hydrocodone Apap (narcotic pain medication) 5-325 milligrams (mg) was available to administer to Resident #22; however, the medication had an expiration date of 03/11.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 05/04/11 at 2:00 PM, revealed the medication was available for use, but had not been administered to the resident since October 2010. She revealed it was her responsibility to ensure expired medications were removed from the cart.</p> <p>An interview with Registered Nurse (RN) #1 and</p>	F 425	<p>CONTINUED</p> <p>4. <i>Monthly audits of expired medications will be conducted by licensed staff and the results of the monthly audits will be turned into Director and Assistant Director of Nursing.</i> The charge nurse will be responsible for assigning the licensed staff to the audits. Staff will remove any expired medications immediately and store them in accordance to facility policy. This process began on 5-18-11 by the charge nurse. <i>The results of the audits are reported by the ADON quarterly to the Performance Improvement Committee.</i></p> <p>5. Corrective actions were completed by 5-23-11.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 425	Continued From page 14 the Charge Nurse, on 05/04/11 at 2:30 PM and 2:50 PM, revealed all staff that passed medications were responsible for the removal of expired medications from the cart. They revealed the pharmacy performed audits of the medication carts periodically. An interview with Pharmacist #1, on 05/04/11 at 3:40 PM, revealed he was not the "usual" pharmacist for the facility. He revealed the pharmacy conducted audits on the medication carts and was responsible for the removal of expired medications. An interview with the Director of Nursing (DON), on 05/04/11 at 4:15 PM, revealed Pharmacist #2 made rounds and recommendations once a month. She revealed he also conducted audits of the medications carts. Pharmacist #2 was not available for an interview during the survey.	F 425			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Extended Care Pavilion and is not an admission that the deficiencies cited are correct. 1. Nursing Assistant #7 received a performance counseling from the Director of Nursing in collaboration with Human Resource on 5-4-11 and documented on 5-21-11. LPN #4 received performance counseling from the Director of Nursing in collaboration with Human Resource on 5-4-11 and documented on 5-18-11 regarding failure to follow facility policy.	5/23/11	

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

PRINTED: 05/17/2011
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 05/04/2011
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F 441	<p>Continued From page 15</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interviews, it was determined the facility failed to maintain an infection control program related to the failure of staff to handle and transport soiled linens as to prevent the spread of infection. A staff member was observed carrying a large amount of unbagged soiled linens in the hall from a resident's room to the dirty linen room. A staff member was also observed to lay a soiled incontinent pad on a pillow and then carry the unbagged soiled pad to the shower room laundry</p>	F 441	<p>CONTINUED</p> <p>2. Rounding with observational audits of the infection prevention practice was conducted by the Director of Nursing and charge nurse on 5-4-11 and 5-5-11 with no additional failures identified.</p> <p>3. An inservice was conducted on 5-18-11 by the Director of Nursing with clinical staff to review the infection prevention policy and procedure: Nursing Responsibilities for Infection Control.</p> <p>4. Secret surveillance is a random observational audit which is conducted ongoing throughout the month and reported monthly to the infection prevention committee. The surveillance is conducted by randomly identified employees of the organization but selected and monitored by the Assistant Director of Nurses. The secret surveillance has been revised to include proper handling of soiled linens and will be monitored in the ongoing audit and reported monthly to the infection prevention committee by the Assistant Director of Nursing this process has been revised on 5-18-11.</p> <p>5. Corrective actions were completed by 5-23-11.</p>		

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

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FORM APPROVED
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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 441	<p>Continued From page 16 hopper.</p> <p>Findings include:</p> <p>A review of the facility's policy "Infection Control Policies and Procedures," dated 05/91, revealed "Linen shall be transported from the resident's room in special linen bags. It shall be placed in a linen hamper stand located outside the resident's room or in the soiled utility room."</p> <p>An observation, on 05/03/11 at 8:10 AM, revealed a Certified Nurse Aide (CNA) #7 carried a large amount of unbagged soiled linens from a resident's room to the dirty linen room. Both of CNA #7's arms were encircled around the large amount of unbagged soiled linen as she carried it through the hall, past several residents' rooms, past the open dining area door, between a rolling food tray cart and a small cart with resident's food trays, to the dirty linen room.</p> <p>An interview with CNA #7, on 05/03/11 at 8:12 AM, revealed she should have placed the soiled linens in a bag before she transported the soiled linens through the hall to the dirty linen room. She stated she usually had a linen bag on her but it was breakfast time and the linen hoppers had been removed from the hall area during the meal service and she was in a hurry.</p> <p>An observation, on 05/03/11 at 8:30 AM, revealed Licensed Practical Nurse (LPN) #4 provided incontinent care to Resident #2 during a skin assessment. LPN #4 removed fecal matter from the resident's buttocks with the incontinent pad he/she was lying on, and then she laid the soiled incontinent pad on a pillow that was on the seat of</p>	F 441		

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

PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 17</p> <p>a chair located by the resident's bed. LPN #4 then carried the unbagged incontinent pad, soiled with fecal matter, from the resident's room to a linen hopper located in the shower room.</p> <p>An interview with LPN #4, on 05/03/11 at 10:00 AM, revealed she did not generally put soiled incontinent pads in a bag. She just takes them to the dirty linen hopper. At 10:30 AM, LPN #4 stated, "I goofed, the soiled incontinent pad should have been in a bag."</p> <p>An interview with the Staff Educational Coordinator, on 05/04/11 at 11:10 AM, revealed dirty linen hoppers should be located just outside a resident's room and staff should not carry unbagged soiled linens down the hall to the dirty linen room.</p> <p>An interview with the Director of Nursing (DON), on 05/04/11 at 6:05 PM, revealed she expected the staff to transport a whole bed of soiled linens through the hall appropriately bagged.</p>	F 441			

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

PRINTED: 05/09/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2011
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 05/03/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.