

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

PRINTED: 07/25/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185234</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>07/11/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALVERT CITY CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 FIFTH AVE CALVERT CITY, KY 42029</b>	
(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  An abbreviated survey (KY #16672) was conducted on 07/08/11 through 07/11/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with a deficiency cited at the highest S/S of "D." KY #16672 was substantiated with a deficiency cited.	F 000		
F 226 SS=D	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 observation, interviews, record review and review of facility policies, it was determined the facility failed to investigate injuries of unknown origin in a timely manner, for one resident (#1), in the selected sample of three. On 07/01/11, Resident #1 was noted with bruising on the middle of his/her chest, on the left side of his/her neck and the right hand. An investigation was not initiated until 07/05/11.  Findings include:  A review of the facility's policy and procedure, "Adult and Child Abuse," undated, revealed "all events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse will be investigated." Further review of the facility's policy and procedure "Resident Protection During Abuse	F 226	F226 1. The Charge Nurse, LPN # 1, and the Unit RN Supervisor, RN # 1, for resident # 1 were verbally instructed by the DON 7/6/2011 on proper protocol, including notification and investigation procedures per facility policy related to abuse and incidents of unknown origin.  2. All residents have the potential to be Affected by the deficient practice.  3. All Staff were in-serviced by the Administrator on the facility abuse policy, including reporting and investigation of abuse; incidents of unknown origin; and care for residents with skin fragility. Charge Nurses and Unit Supervisor were instructed on proper facility protocol for notification and investigation related to abuse or incidents of unknown origin. In-service dates were 7/15, 7/18, 7/25/2011.  4. All incident reports will be delivered by the RN Unit Supervisor to the Interdisciplinary Team daily for review to assure proper notifications and investigations per facility policy  5. Completion Date: July 28, 2011	7/28/2011



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

*[Handwritten Signature]*

TITLE

*ADMINISTRATOR*

(X6) DATE

*7/28/11*

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 226	<p>Continued From page 1</p> <p>Investigation," undated, revealed "the Director of Nursing (DON) or the Charge Nurse will complete the investigation form with written, dated and signed statements from all persons involved. The investigation form and and the written statements from all persons involved will be forwarded to the Administrator within 24 hours of the occurrence. An immediate investigation will be conducted by both the DON and the Administrator."</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/13/10 with diagnoses to include Contracture of both Knee Joints, Abnormal Posture, Muscle Weakness, Dementia, Hypertension, Aphasia and Dysphagia.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 06/20/11, revealed the facility identified Resident #1 to be severely cognitively impaired, non-ambulatory, incontinent of bowel and bladder, and totally dependent on staff for bed mobility and and transfers.</p> <p>A review of the comprehensive care plan, dated 06/30/11, revealed Resident #1 required assistance with bed mobility due to muscle weakness, lack of coordination and Dementia. The resident was assessed for potential for impaired skin integrity related to incontinence, immobility, Dementia, and skin that was desensitized to pain and pressure.</p> <p>An observation of Resident #1, on 07/08/11 at 12:50 PM, revealed the resident was in his/her room at the bedside in a sheep-skin lined gerichair with his/her head reclined and his/her feet elevated. The resident's oxygen (O2) was in place via nasal cannula at 2 liters per minute</p>	F 226			

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F 226	<p>Continued From page 2</p> <p>(LPM). The O2 tubing was padded around the ears and extended down to the middle of the resident's cheeks. A sheep-skin cloth was noted to cover the resident's chest beneath his/her clothing.</p> <p>A review of nurses' notes, dated 07/01/11 at 8:30 AM, revealed Licensed Practical Nurse (LPN) #1 observed Resident #1 with bruising on the middle of his/her chest, on the left side of his/her neck and the right hand. The resident was placed on alert charting at that time.</p> <p>An interview with LPN #1, on 07/08/11 at 3:15 PM, revealed she was the unit nurse on west wing on 07/01/11. At 8:30 AM, she observed Resident #1 with bruising on the chest, neck and right hand. She stated she spoke to the staff who assisted the resident out of bed that morning and asked if they knew how the bruises occurred, and they did not. LPN #1 stated she notified Registered Nurse (RN) #1, who came to the resident's room with her to assess the bruises. She described the chest bruise to be purple colored, approximately 2.5 x 2.5 centimeters (cm) and rectangular in shape with a little white area in the center. She described the neck bruise to be purple in color and circular, and the back of the right hand to be purple in color. LPN #1 stated she did not know why an investigation was not initiated.</p> <p>An interview with RN #1, on 07/10/11 at 8:35 PM, revealed she was the day shift supervisor for the west wing and was called to Resident #1's room by LPN #1, on 07/01/11, to look at bruises on the resident's chest and neck; however, she was not aware of the bruise on the resident's right hand.</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>She described the bruising on the chest to be approximately 1 x 2 cm with a hardened white area in the center that looked like a blister, and was the exact size of the resident's adjustment device on the O2 tubing. She stated there were no witnesses to the bruising, so she completed an incident report and placed it in the mail slot on the DON's door. She stated she was responsible to initiate investigations, but she did not consider these bruises an issue of abuse or neglect. She stated she completed "Abuse/ Neglect" training and was instructed by the DON and the Administrator to conduct investigations.</p> <p>An interview with RN #2, MDS Coordinator, on 07/11/11 at 5:00 PM, revealed the bruising, which were injuries of unknown source, were to be reported to the charge nurse or supervisor immediately. A nursing assessment and incident report were to be completed and forwarded to the DON and the Administrator, who conducted the investigations.</p> <p>A review of the final investigation report, dated 07/08/11, revealed bruises were discovered on Resident #1's chest, neck and right hand on 07/01/11 and an investigation was not initiated until 07/05/11 by the Administrator.</p> <p>An interview with the Administrator, on 07/11/11 at 5:15 PM, revealed LPN #1 and RN #1 completed an assessment on Resident #1 on 07/01/11, and they concluded the bruises on the resident's chest and neck were caused by the O2 tubing. He stated if it was a suspicious injury or bruising, he would have initiated an investigation on 07/01/11; however, he stated that he nor the nurses felt there was anything suspicious about</p>	F 226			

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