

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

PRINTED: 05/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/09/2013
NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR		STATE ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard survey was conducted on 05/07-09/13. Deficient practice was identified with the highest scope and severity being at "D" level.	F 000	<b>Plan of Correction Cumberland Valley Manor Standard Survey 5/6/13-5/9/13</b>	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 05/09/13 revealed a torn wheelchair armrest and fall mat used by Resident A. The wall at the nurses' station on the 200 Hallway had a jagged, open area on the corner that was in need of repair. The bottom of the door to the central bathroom on the 200 Hallway had an area that was open, worn/jagged, and in need of repair.  The findings include:  Review of the "Maintenance Program" policy (undated) revealed the facility would maintain the physical plant and equipment so that it was in proper repair and good working condition at all times.	F 253	<b>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b>  <b>F 253: Housekeeping and Maintenance Services</b> <b>The facility must provide Housekeeping and Maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</b>  <b>Criteria I:</b> The wheelchair arm and floor mat for resident # A have been repaired. The corner by the 200 side nursing station has been repaired. The bottom of the door to the central bathroom on the 200 hallway has been repaired.	

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

TITLE

(X6) DATE

*[Signature]*

Administrator

05/31/13

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 253	Continued From page 1 Observations on 05/07/13 at 11:15 AM and 05/09/13 at 9:45 AM revealed the armrest on Resident #A's wheelchair had a plastic covering that was torn, had sharp edges, and was in need of repair. A fall mat on the floor of the left side of Resident A's bed was torn and in need of repair. An open area in the drywall at the corner of the wall facing the resident hallway at the nurses' station on the 200 Hallway had been filled with a rubber glove that had been taped into place. An open area on the bottom of the door to the central bathroom on the 200 Hallway had jagged edges and was in need of repair.  Interview with the Environmental Director on 05/09/13 at 10:30 AM revealed he was unaware of Resident A's wheelchair armrest and bedside floor mat. According to the Environmental Director, the door to the central bathroom on the 200 Hallway had been overlooked and the open area in the drywall corner at the nurses' station had occurred the previous week and he had not gotten a chance to repair the drywall. The Environmental Director stated walk-through rounds were made daily by the Environmental Director and by Administrative staff, and staff/family/residents could also fill out a referral for repairs and place the referral in a box at the nurses' station. According to the Environmental Director, there had not been any referrals made to the Maintenance Department related to the wheelchair arm, the torn alarm mat, or the central shower room door.	F 253	<b>Criteria 2:</b> An audit was performed by the housekeeping/maintenance staff on 05/30/13-06/04/13 for resident wheelchairs, fall mats, rooms and care areas to identify issues requiring the attention of housekeeping or maintenance. Each item identified was prioritized and scheduled for completion by 06/07/13 under the supervision of the Administrator.  <b>Criteria 3:</b> The housekeeping and maintenance staff have received in-service education by the Administrator and/or Housekeeping Supervisor on routine inspection of the resident rooms and care areas to determine that issues are identified and addressed in a timely manner, as provided on 05/30/13-06/04/13.  <b>Criteria 4:</b> The CQI indicator for the monitoring of housekeeping and maintenance issues will be utilized monthly X 2 months then quarterly as per the CQI calendar supervision of the Housekeeping and Maintenance supervisors.  <b>Criteria 5:</b>  June 10, 2013		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure services provided met professional standards of quality for one of sixteen sampled residents and one unsampled resident (Resident #2). Resident #2 had physician's orders for compression stockings to each foot when the resident woke in the morning and the compression stockings were to be removed at bedtime. Observation of Resident #2 on 05/07/13, 05/08/13, and 05/09/13 revealed staff failed to apply the compression stockings as ordered.</p> <p>The findings include:</p> <p>Interview with the Compliance Officer on 05/09/13 at 1:50 PM revealed the facility did not have a policy related to following physician's orders; however, the Compliance Officer stated following physician's orders was nursing protocol.</p> <p>Review of Resident #2's medical record revealed diagnoses that included Atrial Fibrillation (a heart condition), Peripheral Vascular Disease, and Diabetes. A review of Resident #2's physician's orders revealed orders dated May 2013 for compression stockings to each foot when the resident woke in the morning and to remove the compression stockings from the resident's feet at bedtime. A review of the treatment administration record for 05/07/13, 05/08/13, and 05/09/13</p>	F 281	<p><b>F 281 Services Provided Meet Professional Standards</b> <b>The services provided or arranged by the facility must meet professional standards of quality.</b></p> <p><b>Criteria 1:</b> Resident #2 TED stockings were discontinued on 05/10/13 per physician order.</p> <p><b>Criteria 2:</b> Compliance round observations have been performed by nursing administration staff on 05/28/13-05/31/13 to determine that residents are provided interventions including but not limited to TED stockings, in accordance with MD orders.</p> <p><b>Criteria 3:</b> In-service education has been provided for nursing assistant staff by the DON/ADON on 05/20/13-06/06/13 on the provision of interventions including but not limited to TED stockings in accordance with MD orders</p>		

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F 281	<p>Continued From page 3</p> <p>revealed staff had documented the compression stockings had been administered as prescribed. Review of the comprehensive care plan dated 05/22/13 revealed compression stockings were to be worn every day. However, observations of Resident #2 during the survey conducted on 05/07/13, 05/08/13, and 05/09/13 revealed the compression stockings were not in place for the resident.</p> <p>Interview with Certified Nurse Aide (CNA) #1, CNA #2, and CNA #3 on 05/09/13 at 8:50 AM revealed they were not sure if Resident #2 continued to have a physician's order for the compression stockings. According to the CNAs, Resident #2 often refused to wear the compression stockings and added that the stockings had not been applied to the resident's feet. During the interview, the CNAs found the resident's compression stockings in the resident's drawer.</p> <p>Interview with Resident #2 on 05/09/13 at 8:55 AM revealed the resident would wear the stockings if they were put on.</p> <p>Interview with Registered Nurse (RN) #1 on 05/09/13 at 9:00 AM revealed staff was to ensure the resident's compression stockings were put on in the morning and stated Resident #2 would wear them. RN #1 stated the CNAs should put the stockings on the resident when they assisted the resident to dress. RN #1 said she wrote her initials on Resident #2's treatment record to indicate the compression stockings were in place; however, RN #1 stated she failed to ensure the stockings were in place.</p>	F 281	<p><b>Criteria 4:</b> The CQI indicator for the monitoring of compliance with resident interventions in accordance with MD orders will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/ADON.</p> <p><b>Criteria 5:</b> June 10, 2013.</p>		

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F 281	Continued From page 4  Interview with Licensed Practical Nurse (LPN) #1 on 05/09/13 at 9:10 AM revealed Resident #2 was supposed to wear the compression stockings but often removed them his/her self. According to LPN #1, the nurses sign the treatment sheets to indicate the compression stockings have been applied. However, LPN #1 did not know why Resident #2 did not have the compression stockings on during the observations conducted on 05/07/13, 05/08/13, or 05/09/13.  Interview with the Unit Manager of the 200 Hallway on 05/09/13 at 9:15 AM revealed staff should have applied the compression stockings for Resident #2. According to the Unit Manager, the nurses initial the treatment sheets to indicate a treatment (including compression stockings) has been administered. The Unit Manager stated the compression stockings should be on the CNA care plans as well as the comprehensive care plan.  Interview with the Director of Nursing (DON) on 05/09/13 at 9:40 AM revealed the LPN charge nurses were to ensure treatments were implemented and stated the Unit Managers were to monitor to ensure the treatments were complete. The DON did not know why facility staff had failed to ensure the compression stockings for Resident #2 were not in place as prescribed by the physician.	F 281			
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;	F 328	<b>F 328 Treatment/Care for Special Needs</b> The facility must ensure that residents receive proper treatment and care for the following special services: <b>Respiratory Care.</b>		

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F 328	<p>Continued From page 5</p> <p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure proper treatment and care related to oxygen administration for one of sixteen sampled residents and one unsampled residents (Resident #13). Resident #13 had physician's orders for oxygen to be administered at 3 liters per minute; however, the resident was observed to have oxygen administered at 2.5 liters per minute via nasal cannula.</p> <p>The findings include:</p> <p>A review of the "Oxygen Administration" policy, dated 06/28/00, revealed physician's orders should be checked for liter flow and method of administration. Staff was also to check, at regular intervals, the liter flow rate of the oxygen, the contents of the oxygen cylinder, and the resident's respirations and pulse oximetry readings to determine further need for oxygen therapy.</p> <p>Review of Resident #13's medical record on 05/09/13 revealed a physician's order dated May 2013 for oxygen to be administered via nasal</p>	F 328	<p><b>Criteria 1:</b> Resident #13 receives oxygen in accordance with MD orders as determined by compliance round observations performed on 05/10/13-05/16/13 by the DON/ADON..</p> <p><b>Criteria 2:</b> Compliance round observations have been performed by nursing administration staff on 05/10/13-05/18/13 to determine that residents receive oxygen in accordance with MD orders.</p> <p><b>Criteria 3:</b> In-service education has been provided for the licensed nursing staff by the DON/ADON on 05/30/13- 06/06/13on the provision of oxygen in accordance with MD orders.</p> <p><b>Criteria 4:</b> Observation audits will be conducted by Administrative Nursing staff weekly for all residents receiving oxygen to determine that the oxygen is being provided in accordance with MD orders.</p> <p><b>Criteria 5:</b> June 10, 2013</p>		

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F 328	<p>Continued From page 6</p> <p>cannula at 3 liters per minute.</p> <p>Observation of Resident #13 on 05/07/13 at 11:25 AM revealed oxygen was administered via nasal cannula at 2.5 liters per minute. Observation on 05/09/13 at 10:30 AM, 12:00 PM, and 1:20 PM revealed oxygen was administered via nasal cannula at 2.5 liters per minute.</p> <p>Interview with Resident #13 revealed his/her oxygen should be on at 3 liters per minute. According to Resident #13, he/she was unable to reach the oxygen concentrator and thought the rate was on 3 liters per minute.</p> <p>Interview with Certified Medical Technician (CMT) #1 on 05/09/13 at 1:00 PM revealed the nurses administered the oxygen and she did not know the oxygen flow rate for Resident #13.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 05/09/13 at 1:15 PM revealed the oxygen flow rate for Resident #13 was to be set at 3 liters per minute according to the physician's orders and was not aware the oxygen rate was not accurate.</p> <p>Interview with LPN #2 on 05/09/13 at 1:20 PM also revealed Resident #13's oxygen flow rate should be set for 3 liters per minute via nasal cannula. LPN #2 said walking rounds were performed every two hours and the oxygen rates were monitored at that time. LPN #2 did not know why the oxygen was administered at 2.5 liters instead of 3 as per physician's order.</p> <p>Interview with the Unit Manager on 05/09/13 at 1:25 PM revealed Resident #13's oxygen should be administered at 3 liters per minute and the</p>	F 328			

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F 328	Continued From page 7 nurses were to monitor for the accurate rate of oxygen.	F 328			

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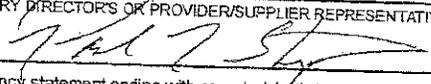
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JUN 26 2013

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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR		STREET ADDRESS, CITY, STATE AND ZIP CODE 301 SOUTH MAIN STREET BIRMINGHAM, KY 42717 Division of Health Care Southern Enforcement Branch	
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- K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>SUPERVISED AUTOMATIC ADDRESSIBLE FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel generator</p> <p>A life safety code survey was initiated and concluded on 05/08/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating</p>	K 000	<p><b>Plan of Correction</b></p> <p><b>Cumberland Valley Manor</b></p> <p><b>Standard Survey</b></p> <p><b>5/6/13 – 5/9/13</b></p> <p><b>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p><b>K062 NFPA 101 Life Safety Code Standard: 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.</b></p>
K 062 SS=D		K 062	

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



TITLE

Administrator

(X6) DATE

05/31/13

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K 062	<p>Continued From page 1</p> <p>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 interview, the facility failed to ensure that sprinkler requirements were maintained. This deficient practice affected one of six smoke compartments, staff, and approximately eighteen residents. The facility has the capacity for 84 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 05/08/13 at 8:40 AM with the Director of Maintenance (DOM), inadequate sprinkler coverage was observed in the men and women's shower room. The walls in the shower room would prevent the sprinkler pattern from reaching all areas in this room.</p> <p>An interview with the DOM on 05/08/13 at 8:40 AM revealed he was not aware of the improper sprinkler coverage.</p> <p>The findings were revealed to the Administrator during exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be</p>	K 062	<p><b>Criteria 1:</b> Quotes for adding sprinkler head drops to both the men and women's shower room on station 2 have been obtained, with installation scheduled to be completed on 06/03/2013. ***Amended date to actual date of completion, see invoice.</p> <p><b>Criteria 2:</b> The entire facility was inspected and was found to have adequate sprinkler coverage throughout.</p> <p><b>Criteria 3:</b> The Administrator and Maintenance Director have reviewed the NFPA requirements for sprinkler head coverage and the scheduled installation of the</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  05/08/2013
NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	Continued From page 2 provided to ensure adequate coverage of the hazard.	K 062	<p>new sprinkler head drops to be completed on 06/03/2013. *** Amended date to actual date of completion, see invoice.</p> <p><b>Criteria 4:</b> The facility will be inspected annually by the Administrator and Maintenance Director to ensure compliance with the NFPA regulation for adequate sprinkler coverage.</p> <p><b>Criteria 5:</b> 06/04/2013 *** Amended date to actual date of completion, see invoice.</p>		