

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

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2012
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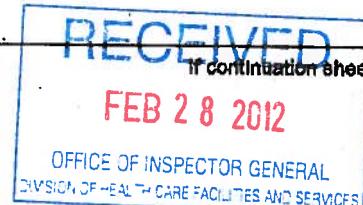
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 908 HWY 127 NORTH OWENTON, KY 40359
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 A standard Health survey was initiated on 01/03/12 and concluded on 01/08/12 and the Life Safety Code survey was conducted on 01/05/12, the highest scope and severity was an "F" with the facility having the opportunity to correct the deficiencies before remedies would be imposed. This was a nursing home initiative survey with entrance to the facility on Tuesday, 01/03/12 at 7:30 PM.	F 000		
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's surety bond and resident trust fund balance sheets, it was determined the facility failed to assure their surety bond covered resident funds in the event the facility lost any resident funds. The resident trust fund balance was twenty-four thousand one hundred and sixty-five dollars and ninety-nine cents (\$24,165.99) and the facility's surety bond was for twenty thousand dollars (\$20,000). The findings include: Review of the facility's policy for Surety Bonds,	F 161	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F161 1. Center surety bond was increased to \$30,000 on 1/9/12 by the Business Office Manager. 2. Residents with a resident trust account have the potential to be affected if the account balance exceeds the surety bond coverage. 3. The Administrator re-educated the Business Office Manager on 1/16/12 regarding the requirements of 483.10(c)(7) Security of personal funds. 4. The Administrator will review the amount of the surety bond monthly for three months to determine adequate protection for resident funds. Any concerns identified will	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kara M. Meredith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-27-12</i>
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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 161	Continued From page 1 undated, revealed the facility would maintain a surety bond that exceeded the amount of the residents' personal funds: Review of the facility's Resident Trust Fund revealed the balance was twenty-four thousand one hundred and sixty-five dollars and ninety-nine cents (\$24,165.99) and the facility's surety bond was for twenty thousand dollars (\$20,000). Interview with the Business Office Manager, on 01/08/11 at 1:00 PM, revealed the facility did not have enough surety bond to cover the residents' trust account balance. She stated the account did not usually have that much money. Interview with the Administrator, on 01/16/12 at 3:00pm, revealed a request had been made to increase the surety bond to cover the balance of money in the resident trust.	F 161	be addressed. The results of the reviews will be brought by the Administrator to the Performance Improvement Committee for review and further recommendation. <i>5.2/24/12 2-19-12 per Adm</i> F164 <i>by PO 3-13-12</i>	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164	1. Re-education was provided to CNA #9 regarding providing privacy during care on 1/31/12 by the Director of Nursing Services. LPN #8 is no longer employed by the center. 2. Rounds were completed by the Administrator, Director of Nursing Services, and Social Services Director on 1/31/12 to determine residents' privacy was respected and maintained to include the use of privacy curtains. 3. Administrative, Nursing, Housekeeping, Maintenance, Therapy and Dietary Staff were re-educated by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors on providing privacy during care including using privacy curtains by 2/5/12. 4. The Director of Nursing Services, Nursing Supervisor, and/or Unit Managers will conduct rounds three (3) times weekly for four (4) weeks, then weekly for five (5) months to determine residents' privacy is maintained and privacy curtains are being	



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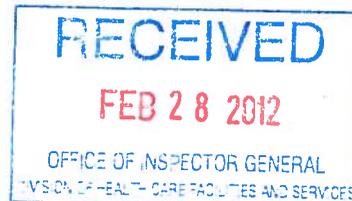
F 164	<p>Continued From page 2</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide privacy during a skin assessment and clothing change for one (1) of nineteen (19) sampled residents, Resident #6.</p> <p>The findings include:</p> <p>Observation of Resident #6, on 01/04/12 at 10:40 AM, revealed the facility had completed a skin assessment. Certified Nurse Assistant (CNA) #9 assisted Licensed Practical Nurse (LPN) #8 with the completed skin assessment. The privacy curtain between Resident #6 and #3 remained open throughout the entire skin assessment.</p> <p>Continued observation, of Resident #6, on 01/04/12 at 10:49 AM, revealed CNA #9 dressed Resident #6 unassisted immediately after the skin</p>	F 164	<p>used during resident care. The Director of Nursing Services will report results of these rounds to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2-24-12 2-19-12 per Adm key PB 3-13-12</p>	
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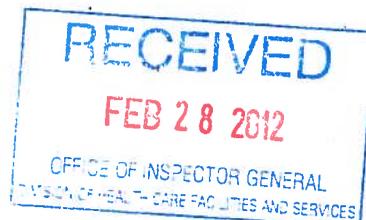
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F 164	Continued From page 3 assessment. The privacy curtain between Resident #3 and Resident #6 remained open while Resident #6 was dressed in his/her adult brief, pants and shirt. Interview with LPN #8, on 01/04/12 at 12:06 PM, revealed the curtain should have been pulled during the skin assessment. The curtain was to provide the resident with privacy while care was provided. Interview, on 01/04/11 at 12:20 PM, with CNA #9 revealed the curtain was between the residents to assure privacy when care was provided. She forgot to pull the curtain and it should have been pulled. Interview, on 01/04/12 at 2:30 PM, with the Director of Nursing (DON) revealed the staff was trained on resident privacy and care. The curtains are located in all of the room to ensure each person has privacy available to them.	F 164	F241 1. Resident #6 was provided with a dignity cover for their urinary collection bag on 1/6/12 by the Certified Nursing Assistant (CNA). CNA #10 was re-educated by the Director of Nursing Services regarding resident dignity and staff interaction with residents during mealtime on 2/1/12. 2. Rounds were completed on 1/6/12 by the Director of Nursing Services, Staff Development Coordinator, Central Supply Clerk and/or Unit Managers to determine that residents who require catheters have a dignity cover for their urinary collection bag. Residents residing at the center are benefited from appropriate staff to resident interactions.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined the facility failed to provide and promote dignity in a manner that recognized the individuality for two (2) of nineteen (19) sampled	F 241	3. Licensed Nurses and Certified Nursing Assistants were re-educated by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors on maintaining and enhancing resident dignity and respect by 2/5/12. This education includes the use of dignity covers for urinary collection bags and appropriate staff interaction with residents during mealtime. 4. The Administrator; Receptionist; Director of Marketing and Admissions; Central Supply Clerk; Maintenance Director; Social Services Director; Staff Development Coordinator; Nutritional Services Director;		



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F 241	<p>Continued From page 4</p> <p>residents, Resident #8 and Resident #12. The facility failed to provide a dignity cover for Resident #6's urinary collection bag and failed to provide dignity and respect for Resident #12 by the lack of any interaction while the lunch meal was fed to the resident.</p> <p>The findings include:</p> <p>1. Clinical record review of the quarterly minimum data set (MDS), for Resident #8 and dated 11/07/11, revealed the facility readmitted the resident on 03/11/11 with the diagnoses of Malignant Neoplasm of the Prostate, Hypertension and Cervical Spondylosis without Myelopathy. The facility assessed Resident #6 as non-interviewable.</p> <p>Observation, of Resident #6, on 01/04/12 at 10:50 AM, revealed he/she was dressed by CNA #9 and the urinary collection bag (UCB) was hung on the right side of the bed without a cover over the UCB. The right side of the resident's bed faced his/her roommate and was in view of the hall. The bed was lowered to the lowest level.</p> <p>Observations, of Resident #6, on 01/04/12 at 11:03 AM, 11:20 AM, 11:30 AM and at 11:47 AM, revealed the resident's urinary collection bag was not covered with a dignity cover bag and was lying on the floor and on the edge of the fall mat. The resident's room door remained opened to the hall and the roommate remained in the room.</p> <p>Observation of Licensed Practical Nurse (LPN) #8, on 01/04/12 at 12:05 PM, revealed she instructed another staff to remind the CNA to check and make sure the UCB were not on the</p>	F 241	<p>Director of Nursing Services; Activity Staff; Housekeeping Supervisor; Health Information Manager; and/or Unit Managers will monitor meal times five (5) times weekly for three (3) months, then once weekly for three (3) months to observe for appropriate staff to resident interaction. The Director of Nursing Services, Staff Development Coordinator, and/or Unit Managers will conduct rounds three (3) times weekly for four (4) weeks, then weekly for five (5) months to determine residents' dignity is maintained to include the use of dignity covers for urinary drainage bags. The Administrator and/or Director of Nursing Services will report trends of meal observations for appropriate staff interaction and findings of dignity rounds, including use of dignity covers for urinary drainage bags to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2-19-12 per Adm. by PB 3-13-12</p>	



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F 241	<p>Continued From page 5 floor.</p> <p>Interview, with LPN #8, on 01/04/12 at 12:06 PM, reports the urine collection bag was not suppose to be on the floor. She reported the UCB on the floor was a concern for a potential infection. She reported the UCB was supposed to be covered with a dignity bag to conceal the urine. She reported there was not a dignity cover bag in the room and she did not obtain the needed item.</p> <p>Interview, on 01/04/11 at 12:20 PM, with CNA #8 revealed the urine bags were to be covered, but she forgot to put the cover on the UCB. She reported the UCB was not supposed to be on the floor. She reported the patient had a risk for an infection when the UCBs are on the floor.</p> <p>Interview, on 01/04/12 at 2:30 PM, with the Director of Nursing (DON) reported it was the facility practice to keep the UCB off of the floor, as this was a concern for potential infections. She stated the best practice for dignity was to keep the urine bags covered and the staff had been trained to do so.</p> <p>2. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 07/01/05 with diagnoses of Head injury/2002, Pneumonia, Dysphasia, Abnormal Posture, Quadriplegia, and Aspasia. Review of the Minimum Data Set (MDS) Assessment dated</p>	F 241		



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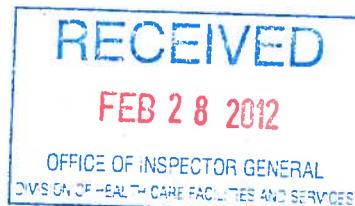
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F 241	Continued From page 8 10/19/11 and the last annual assessment dated 07/01/11 indicated the facility assessed the resident as unable to determine cognition, required extensive assistance with one staff for dressing, eating, hygiene and bathing. Review of the comprehensive Care Plan for Resident #12 revealed the facility initiated a care plan 04/21/11 and revised the care plan on 11/02/11 for potential for aspiration pneumonia related to dysphasia. The resident required a mechanically alter diet and was fed by staff. Interventions included house puree diet with pudding thick liquids, feeder coated spoons, and position the resident at 70-90 degrees for oral intake. Observation, on 01/04/12 at 12:10 PM, of Resident #12 revealed the resident was sitting up in a specialty chair, in the dining room ready for lunch. The residents head did not appear elevated at 70-90 degrees. Certified Nursing Assistant (CNA) #10 was feeding Resident #1 and was observed not speaking to the resident while feeding multiple bites. Interview with the 100 hall Unit Manager, on 01/06/12 at 2:30 PM, revealed the staff should be talking with the residents as they are providing care and she was not aware of the situation with Resident #1. Interview with the Director of Nursing, on 01/06/12 at 3:00 PM, revealed it was not acceptable for staff to not ensure dignity for the residents and they should be interacting with the residents as they are providing care.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		



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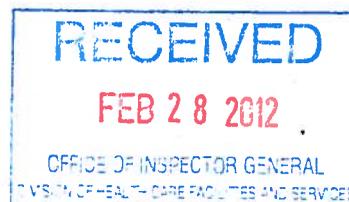
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F 246	Continued From page 7 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to accommodate the needs for two (2) of nineteen (19) sampled residents. (#1, and # 13). The facility failed to provide Resident #1 with a bed that was long enough for his height after the staff determined the current bed was too short and caused pressure on the feet. The facility failed to provide Resident #13 with a wheelchair recommended by Therapy on 10/27/11 after it was determined the wheelchair the resident was currently using was inappropriate and caused the resident back pain. The findings include: Review of the facility's policy Care and Services, effective 01/08, revealed the Interdisciplinary Team will provide care and services to residents with reasonable accommodation of resident's individual needs and preferences. Interview with the 100 hall Unit Manager and	F 246	F246 1. Resident #1 received an alternate bed on 1/5/12 by the nurse. Resident #13 was provided with an alternate chair on 1/5/12 by the Staff Development Coordinator. Resident #13 was re-assessed for pain by the nurse on 1/5/12. 2. Center rounds were completed by the Administrator, Director of Nursing Services, Restorative Aide, Therapy Program Manager, Unit Managers, Social Services Director and Central Supply by 2/2/12 to review that current residents' needs are accommodated to include appropriate bed lengths and wheel chairs are provided. Any needs identified were addressed at that time. 3. Re-education was provided to Therapy staff and Licensed Nurses by the Administrator, Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors regarding inter-departmental communication to include accommodation of needs such as specialty beds and wheelchairs for residents by 2/5/12. 4. The Therapy Program Manager; Director of Nursing Services; Staff Development Coordinator; Unit Managers; and/or Social Services Director will review Nursing to Therapy Communication forms and 24 Hour Reports to identify residents who may need specialty equipment including		



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F 246	<p>Continued From page 8</p> <p>Licensed Practical Nurse (LPN) #8, on 01/04/12 at 4:00 PM, revealed Resident #1 had several bed frames, at least two (2) and possibly three (3), and that the one he/she was presently in was the longest bed in the facility. They stated they would have to make other arrangements with administration to get a new bed that was long enough.</p> <p>Interview with the 100 Unit Manager, on 01/06/12 at 2:30 PM, revealed, discussions regarding the need for a longer bed for Resident #1 had occurred "many times" with administration. In morning stand up meetings, however, she had no documentation of those discussions.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 03/30/11 with diagnoses including Tracheotomy, Aphasia related to Cerebral Vasoular Accident, Chronic Obstructive Pulmonary Disease, Gastronomy Tube, Insulin Dependent Diabetes, and Chronic Respiratory Failure. The resident had two (2) hospital admissions, 06/12/11-06/25/11 and 07/23/11-08/02/11.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment for Resident #1, dated 04/08/11, and the Quarterly MDS Assessment, dated 12/02/11, revealed the facility assessed Resident #1 as requiring extensive assistance with two person physical assist for transfers, unable to complete cognitive assessment related to inability to speak, functional limitation of range of motion impaired on both sides and upper and</p>	F 246	<p>alternate beds or wheelchairs to accommodate needs five (5) times weekly. Additionally, the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Therapist will complete rounds weekly for four (4) weeks, then monthly for two (2) months to further assist in identifying resident care needs to include improved fitting beds or wheelchairs. The center will utilize a tracking system on the conference room white board to ensure any specialty equipment is ordered and received as timely as possible. The Director of Nursing Services and/or Administrator will report outcome of rounds to determine accommodation of needs and the order and/or receipt of equipment to the Performance Improvement Committee monthly for three (3) months for further review and recommendation.</p> <p>5. 2/24/12 2-19-12 per adm by PB 3-13-12</p>	



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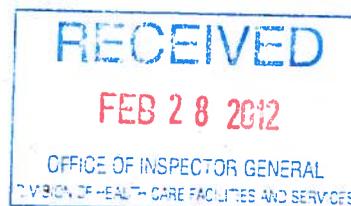
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F 246	<p>Continued From page 9</p> <p>lower extremities. Review of the Comprehensive Care Plan initiated on 04/12/11 for Resident #1 revealed the facility developed a care plan for potential for skin breakdown related to immobility syndrome and history of CVA with interventions that included: Pressure relieving/ reducing devices, low air loss mattress, two assist with bed mobility, bathing, and incontinence care and to turn and reposition every two hours.</p> <p>Review of the Nutritional Assessment for Resident #1 completed 12/27/11 revealed the residents height was 72 inches and weight of 183 pounds.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 01/05/12 at 5:20 PM, revealed she had provided care for Resident #1 on a regular basis. She stated the resident required total care with bathing, was turned every two hours, and the resident had no voluntary movements of the extremities. CNA #5 stated they had to "constantly" lift the resident up in the bed because the resident was so tall to keep the resident's feet from touching the foot board. She stated she had observed the resident's feet touching the footboard several times. She stated the facility got a new bed for the resident on 01/04/12.</p> <p>Interview with CNA #8, on 01/06/12 at 9:40 AM, revealed she had provided care for Resident #1 and the resident was on an air mattress. She stated "before the resident got the new bed with the extension, he/she's head would be at the top of the bed and his/her's feet would hang over the</p>	F 246			



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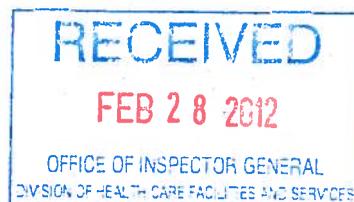
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/06/2012
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
(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 246	<p>Continued From page 10 foot board".</p> <p>Interview with the Occupational Therapist Registered/Licensed (OTR/L), on 01/06/12 at 1:00 PM, revealed she had worked with Resident #1 and she had reported to staff many times that Resident #1's feet were against the foot board and that the resident had to be pulled up in the bed.</p> <p>Interview with the Maintenance workers, on 01/06/12 at 4:30 PM, revealed housekeeping was in charge of changing beds for residents. He stated none of the beds in the facility had the ability to extend, and that's why they ordered the current bed Resident #1 was in so they could extend the bed.</p> <p>Interview with the Housekeeping Manager, on 01/06/12 at 5:00 PM, revealed the longest bed in the facility was 80 inches long with no ability to extend the bed. She stated Resident #1 was originally in a shorter bed (79 inches) but was changed to the 80 inch bed "months ago". She stated she still heard Resident #1 would slide down in the bed and hit the footboard.</p> <p>Interview with the Director of Nursing, on 01/06/12 at 3:00 PM, revealed she had been at the facility about three weeks and that no one had spoke to her or reported to her the need for a longer bed for Resident #1. She stated there was a potential complication of skin breakdown if the resident was not in a bed big enough.</p>	F 246			



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

PRINTED: 01/23/2012
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OMB NO. 0938-0391

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F 246	Continued From page 11 Interview with the Administrator, on 01/06/12 at 3:30 PM, revealed she had just taken over as Administrator on December 27, 2011. She stated the previous Administrator was here and trained her. She stated she had no knowledge of Resident #1 needing a larger bed from either the previous administrator or staff at the facility. Review of the clinical record for Resident #13, revealed the facility admitted the resident with diagnoses of Heart Failure and Hypertension. The facility completed an annual Minimum Data Set (MDS) assessment on 12/05/11 which revealed the resident was unable to ambulate and required extensive assistance for transfers and hygiene. The facility documented the resident was interviewable after completing a Brief Interview for Mental Status (BIM). Interview with Resident #13, on 01/05/12 at 11:40 AM, revealed the resident had complained, months ago, of back pain caused by his/her wheelchair back. The resident stated the wheelchair back was too low and did not provide enough support and caused slumping down in the chair and pain. The resident stated therapy staff	F 246			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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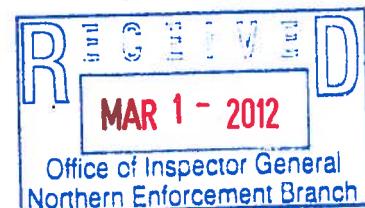
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F 246	<p>Continued From page 12</p> <p>had evaluated the wheelchair and sent the administrator the measurements required for a new wheel chair that was appropriate for the resident. The resident stated the wheelchair never arrived.</p> <p>Interview with the Rehabilitation Director, on 01/05/12 at 12:12 PM, revealed Resident #13's wheelchair was assessed by therapy on 10/27/11 and was determined to be inappropriate and causing the resident back pain. She stated the information for a new wheelchair was provided to the administrator on 10/27/11.</p> <p>Review of the therapy recommendation for Resident #13's new wheelchair, revealed the seat should be twenty-four (24) by eighteen (18) inches. The seat height should be sixteen (16) inches and the back height should be eighteen (18) inches. The resident was complaining of back pain from the wheel chair back.</p> <p>Interview with the Administrator, on 01/06/11 at 1:00 PM, revealed the wheelchair for Resident #13 was not ordered until 01/02/12.</p> <p>Review of the Purchase Order Form provided by the Administrator, revealed the seat size ordered was twenty-four (24) by eighteen (18) inches, and did match the therapy recommendations. However, the therapy recommendations for seat height, sixteen (16) inches, and back height, eighteen (18) inches were not noted on the Purchase Order Form.</p>	F 246			

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359	
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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and the facility's policy, it was determined the facility failed to provide medically-related social services for two (2) of nineteen (19) sampled residents (Residents #1 and #13). Resident #1 had a bed that was too short and Resident #13 had a wheelchair that caused him pain and was assessed by therapy to be inappropriate.</p> <p>The findings include:</p> <p>Review of the facility policy for Social Services, undated, revealed residents would received medically-related social services.</p> <p>Interview with the Social Services Director (SSD), on 01/06/12 at 5:50 PM, revealed she was responsible for providing residents with medically-related social services.</p> <p>1. Interview with Resident #13, on 01/05/12 at 11:40 AM, revealed the resident had complained, months ago, of back pain caused by his/her</p>	F 250	<p>F250</p> <p>1. Resident #1 received an alternate bed on 1/5/12 by the nurse. Resident #13 was provided with an alternate chair on 1/5/12 by the Staff Development Coordinator. Resident #13 was re-assessed for pain by the nurse on 1/5/12.</p> <p>2. Center rounds were completed by the Administrator, Director of Nursing Services, Restorative Aide, Therapy Program Manager, Unit Managers, Social Services Director and Central Supply by 2/2/12 to review that current residents are provided medically related social services to include appropriate bed lengths and wheel chairs as needed. Any needs identified were addressed at that time.</p> <p>3. The Social Services Director was re-educated on 1/26/12 by the Administrator on the requirements of the center to provide medically related social services for each resident, including making arrangements for obtaining equipment.</p>	



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

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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 HWY 127 NORTH OWENTON, KY 40369	
(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 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and the facility's policy, it was determined the facility failed to provide medically-related social services for two (2) of nineteen (19) sampled residents (Residents #1 and #13). Resident #1 had a bed that was too short and Resident #13 had a wheelchair that caused him pain and was assessed by therapy to be inappropriate.</p> <p>The findings include:</p> <p>Review of the facility policy for Social Services, undated, revealed residents would received medically-related social services.</p> <p>Interview with the Social Services Director (SSD), on 01/06/12 at 5:50 PM, revealed she was responsible for providing residents with medically-related social services.</p> <p>1. Interview with Resident #13, on 01/05/12 at 11:40 AM, revealed the resident had complained, months ago, of back pain caused by his/her</p>	F 250	<p>F250</p> <p>1. Resident #1 received an alternate bed on 1/5/12 by the nurse. Resident #13 was provided with an alternate chair on 1/5/12 by the Staff Development Coordinator. Resident #13 was re-assessed for pain by the nurse on 1/5/12.</p> <p>2. Center rounds were completed by the Administrator, Director of Nursing Services, Restorative Aide, Therapy Program Manager, Unit Managers, Social Services Director and Central Supply by 2/2/12 to review that current residents are provided medically related social services to include appropriate bed lengths and wheel chairs as needed. Any needs identified were addressed at that time.</p> <p>3. The Social Services Director was re-educated on 1/26/12 by the Administrator on the requirements of the center to provide medically related social services for each resident, including making arrangements for obtaining equipment. Therapy staff and Nursing Staff were re-educated by the Administrator, Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisor by 2/22/12 to notify the Social Services Director of a resident's need for any additional services or equipment such as appropriate sized beds or wheelchairs.</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 14</p> <p>wheelchair back. The resident stated the wheelchair back was too low and did not provide enough support and caused slumping down in the chair and pain. The resident stated therapy staff had evaluated the wheelchair and sent the administrator the measurements required for a new wheelchair that was appropriate for the resident, however, the new wheelchair never arrived.</p> <p>Interview with the Rehabilitation Director, on 01/05/12 at 12:12 PM, revealed Resident #13' wheelchair had been evaluated on 10/27/11 and was found to be inappropriate in size for the resident. She stated the appropriate measurements were obtained and sent to the administrator so a wheelchair could be ordered. She stated the request included a notation that the resident's wheelchair caused an increase in back pain for the resident.</p> <p>2. Observations of Resident #1, on 01/04/12 at 9:30 AM, revealed the resident resting in bed on his/her back on a specialty mattress. His/her feet were at the end of the bed, with minimal space (inches) between the foot board and the resident's feet. The feet and heels were not floated or elevated. The resident could not answer questions.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 03/30/11 with diagnoses including Tracheotomy, Aphasia related to Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease,</p>	F 250	<p>4. The Therapy Program Manager; Director of Nursing Services; Staff Development Coordinator; Unit Managers; and/or Social Services Director will review Nursing to Therapy Communication forms and 24 Hour Reports to identify residents who may need specialty equipment including alternate beds or wheelchairs to accommodate needs five (5) times weekly. The Social Services Director will log requests from Therapy or Nursing Staff to assist in accommodating a resident's needs, and needs identified on Nursing to Therapy Communication forms and/or 24 Hour Reports and his/her action or involvement in addressing. The Social Services Director will report trends of the log to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/21/12 2-19-12 per Action by PB 3-12-12</p>		



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F 250	Continued From page 15 Gastronomy Tube, Insulln Dependent Diabetes, and Chronic Respiratory Failure. Interview with the SSD, on 01/06/12 at 5:50 PM, revealed she was aware of Resident #13's problems with his/her wheelchair. She stated the Administrator was notified by the Rehabilitation Director that Resident #13 needed a new wheelchair. She stated she made no attempts to resolve the issue and did not speak with the resident, at any time, regarding the wheelchair or the resident's pain. She stated she was not aware of Resident #1's bed being too short for the resident. She stated she was not involved in assisting residents obtain needed medical equipment to acheiva residents' highest functional well-being.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 16 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility's policy, it was determined the facility failed to develop comprehensive care plans for two (2) of nineteen (19) sampled residents (Resident #8 and Resident #9). The facility failed to develop a care plan to address Resident #8's inability to manage swallowing large boluses of food and fluid and Resident #9's use of an indwelling catheter and development of a Urinary Tract Infection. The findings include: Review of the facility's policy for Aspiration Precautions, undated, revealed consultation with a Speech Therapist for techniques to improve swallowing should be considered for residents with difficulty swallowing. Record review of the facility policy, Care	F 279	F279 1. Resident #8 was re-assessed by the Speech Therapist on 1/20 - 1/27/12 to determine current care needs and/or recommendations for care. There were no further recommendations at that time. Resident #8's care plan was reviewed and revised on 1/9/12 by the Licensed Nurse and is reflective of current care needs. Resident #9's catheter was discontinued on 1/5/12; their care plan is reflective of current care needs. 2. Current resident care plans were reviewed by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, MDS Coordinators and Nursing Supervisor by 2/5/12 to determine they are reflective of current care needs. 3. Licensed Nurses were re-educated by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors regarding revision and updates of resident care plans. 4. The Director of Nursing Services and/or MDS Coordinators will review ten (10) resident care plans weekly for four (4) weeks, then monthly for six (6) months to determine care plans are updated and meet	



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F 279	<p>Continued From page 17</p> <p>Standards, dated January 2008, revealed it was the policy of the center was to provide necessary care and services to assist each resident to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well being in accordance with a comprehensive assessment and plan of care. Care is documented in the medical record in accordance with State and Federal regulations.</p> <p>1. Review of the clinical record for Resident #8 revealed the facility admitted the resident, with diagnoses of Diabetes and Hypertension, on 03/02/11. The facility completed an admission Minimum Data Set (MDS) on Resident #8 on 03/10/11 and assessed the resident was independent with eating. The resident was noted to have a history of recurrent respiratory tract infections. On 04/07/11, Speech Therapy (ST) completed an evaluation which revealed the resident had a decreased bolus control while eating and drinking. The ST recommended the resident be placed on reflux precautions, keep the chin level while eating and drinking, swallow slowly, take small bites and sips, and sit at a ninety (90) degree angle while eating.</p> <p>Observation of Resident #8, on 01/04/12 at 12:20 PM and on 01/05/12 at 12:25 PM, revealed the resident eating meals in the main dining room. The resident was observed, at both meals, to bow his/her head while chewing and swallowing and to ingest large bites of food. The facility nursing staff did not intervene or provide reminders or cueing of the resident during these meals.</p>	F 279	<p>the care needs of the resident. The Director of Nursing Services and/or MDS Coordinator will report results of this review monthly to the Performance Improvement Committee for six (6) months for further review and recommendation.</p> <p>5-2/24/12 2-19-12 per action by PS 2-13-12</p>		



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F 279	<p>Continued From page 18</p> <p>Review of the comprehensive care plan, last revised on 10/19/11, for Resident #8, revealed the resident had a history of respiratory distress, however, there was no evidence the facility utilized the Speech Therapy recommendations to promote the resident's highest functional well-being.</p> <p>Interview with LPN #1, on 01/04/12 at 9:00 AM, revealed she was not aware of a Speech Therapy evaluation or of the recommendations made for Resident #8. She stated the resident had a history of respiratory difficulties and infections and the recommendations should have been discussed with the physician and implemented to prevent further problems.</p> <p>Interview with the Director of Nursing, on 01/06/12 at 2:30 PM, revealed the recommendations from the Speech Therapist should have been given to the physician and implemented.</p> <p>2. Review of the medical record for Resident #9, revealed the facility admitted the resident on 11/02/08 with diagnoses of Diabetes Mellitus, Chronic Kidney Disease, and History of Urinary Tract Infections. The quarterly Minimum Data Set (MDS) assessment, dated 11/11/2011, revealed the resident required extensive assistance of one</p>	F 279		



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

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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 HWY 127 NORTH OWENTON, KY 40359
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F 279	<p>Continued From page 19</p> <p>(1) person to provide dressing, and hygiene was assessed as total dependence with the assistance of one (1). The resident was incontinent of bowel and bladder. Resident #9 was also noted to have a Urinary Tract Infection (UTI) over the past thirty (30) days and was at risk for future UTI's. Resident #9 had a physician's order dated 01/02/12 for an indwelling catheter for Urinary Retention and UTI symptoms. The order included instructions for indwelling catheter care. Review of the comprehensive care plan for Resident #9 revealed no evidence a care plan was developed to address the indwelling catheter or the UTI.</p> <p>Observation, on 01/05/12 at 9:25 AM, revealed Resident #9 had an indwelling catheter in place connected to a down drain bag.</p> <p>Interview, on 01/05/12 at 2:10 PM, with LPN #5 revealed she was not sure if a care plan had been developed for Resident #9's indwelling catheter or the UTI.</p> <p>Review of the clinical record revealed no evidence the facility developed a care plan for Resident #9's indwelling catheter or the UTI.</p> <p>Further interview with LPN #5, on 01/05/12 at 2:10 PM, revealed a care plan should have been developed for the resident's indwelling catheter and UTI by the nurse on the unit when the events occurred. She stated the facility policy was to develop residents' care plans as care needs were identified</p> <p>Interview with the Minimum Data Set (MDS) Nurse, on 01/06/12 at 2:00 PM, revealed the</p>	F 279		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

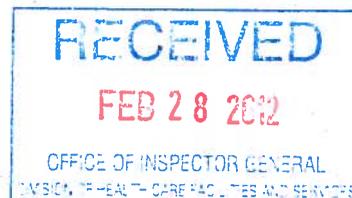
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359
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F 279	Continued From page 20 facility should develop care plans based on resident needs.	F 279		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility's policy for Care Standards, it was determined the facility failed to meet professional standards of nursing care for one (1) of nineteen (19) sampled Residents as evidenced by the facility's failure to follow their policy on securing Resident #9's Indwelling catheter.</p> <p>The findings include:</p> <p>Record review of the facility's policy for Care Standards, dated January 2008, revealed... necessary care and services will be provided to assist each resident to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well being in accordance with a comprehensive assessment and plan of care. Care is documented in the medical record in accordance with State and Federal regulations.</p> <p>Review of the medical record for Resident #9, revealed the facility admitted the resident on 11/02/08 with diagnoses of Diabetes Mellitus, Difficulty Walking, Chronic Kidney Disease and History of Urinary Tract Infections. The facility completed a quarterly Minimum Data Set (MDS) assessment, dated 11/11/11, which revealed the</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> 1. Resident #9's indwelling catheter was discontinued by the physician on 1/5/12. 2. Residents with an indwelling catheter were reviewed on 1/6/12 by the Director of Nursing Services, Staff Development Coordinator, Central Supply Clerk and/or Unit Managers to determine catheters were secured. A care plan review of resident's with indwelling catheters was completed by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, MDS Coordinators and Nursing Supervisor to determine catheters/catheter care was care planned. Any identified concern was addressed immediately. 3. Licensed Nurses and Certified Nursing Assistants were re-educated by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors regarding the procedure to secure a resident's catheter, and implementing, revising, and following resident care plans. 4. The Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors will review each resident with an indwelling catheter to determine catheters are secured weekly for four (4) weeks, then monthly for five (5) months. The Director of Nursing Services will report findings of secured catheter 	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

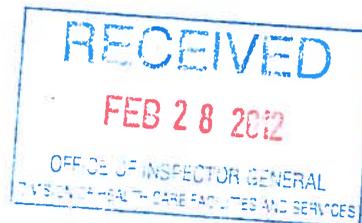
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359
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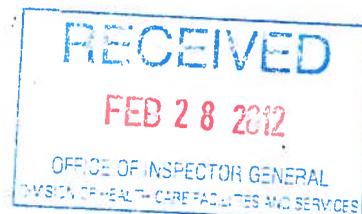
F 281	<p>Continued From page 21</p> <p>resident required extensive assistance of one (1) person for toileting and total assistance for bathing. The resident was incontinent of bladder and bowel. Resident #9 had experienced a Urinary Tract Infection (UTI) over the past thirty (30) days. On 01/02/12, the physician ordered an indwelling catheter and catheter care. Review of the comprehensive care plan revealed no evidence the facility addressed the catheter or the care of the catheter.</p> <p>Observation, on 01/05/12 at 9:25 AM, revealed Resident #9's Indwelling catheter was not secured during the skin assessment and remained unsecured after the skin assessment and peri-care was completed by License Practical Nurse (LPN) #5 and Certified Nursing Assistant (CNA) #1.</p> <p>Interview, on 01/05/12 at 3:00 PM, with Resident #9 revealed his/her indwelling catheter was not secured.</p> <p>Interview, on 01/05/12 at 2:10 PM, with LPN #5 stated she was not sure if Resident #9's indwelling catheter was care planned.</p> <p>Record review, on 01/05/12 at 2:10 PM, with LPN #5 revealed the absence of Resident #9's indwelling catheter on the nursing care plan.</p> <p>Interview, on 01/06/12 at 9:15 AM, with CNA #1 revealed Resident #9's indwelling catheter was not secured according to facility policy; she further revealed since the catheter was not secured, the catheter could be pulled out causing serious damage to the resident.</p>	F 281	<p>review to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. The Director of Nursing Services and/or MDS Coordinators will review ten (10) resident care plans weekly for four (4) weeks, then monthly for five (5) months to determine care plans are updated and meet the care needs of the resident. The Director of Nursing Services and/or MDS Coordinator will report the findings of the care plan reviews to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2:19:12 pm fsh pm PB 3-13-12</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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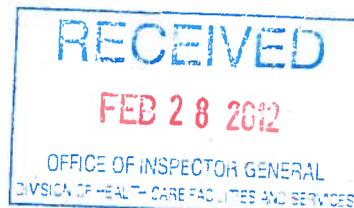
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359	
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F 281	Continued From page 22 Interview, on 01/06/12 at 9:25 AM, with LPN #5 revealed she did not know if the facility had a policy on securing indwelling catheters for residents and she stated the risk for catheters not being secured was being pulled out, causing damage/trauma to the resident. Interview, on 01/06/12 at 3:40 PM, with the Director of Nursing (DON), revealed all nursing staff were responsible to secure residents' indwelling catheters and were trained on the care and maintenance of catheters per nursing practice. Interview, on 01/06/12 at 4:10 PM, with the Nurse Consultant for the facility, revealed the nursing staff had access to the 6th edition of Clinical Nursing Skills & Techniques by Perry and Potter according to facility policy. Review of the 6th edition of Clinical Nursing Skills & Techniques by Perry and Potter, chapter 32 page 1082 revealed procedures for an indwelling catheter instructed the staff to anchor/secure catheters to reduce the possibility of tissue injury.	F 281	F282 1. Resident #3's fall mats were replaced by the Certified Nursing Assistant on 1/6/12. Resident #12 was re-screened by the Speech Therapist on 1/30/12 to determine their positioning needs during meal service. CNA #9 was re-educated on 1/31/12 by the Director of Nursing Services regarding following CNA care cards. CNA #2 will be included in nursing staff education. LPN #8 is no longer employed by the center. 2. Current resident care plans/CNA care cards were reviewed by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, MDS Coordinators and Nursing Supervisor by 2/5/12 to determine interventions are being provided as indicated in the residents' plan of care. Any issues identified were corrected. 3. Licensed Nurses and Certified Nursing Assistants were re-educated by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors regarding following the residents care plans/CNA Care Cards. 4. The Director of Nursing Services and/or MDS Coordinators will review ten (10) resident care plans weekly for four (4) weeks, then monthly for five (5) months to determine that interventions are	
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 observation, interview, and record review, and the facility's care plans, it was	F 282		



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

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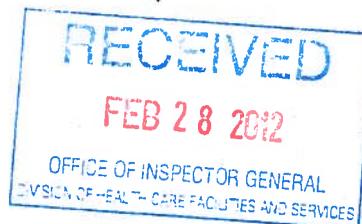
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F 282	<p>Continued From page 23</p> <p>determined the facility failed to follow the comprehensive care plan for two (2) of nineteen (19) sampled residents, Resident #3 and Resident #12. The facility failed to meet the positioning needs during meal service for Resident #12 and failed to place the fall mats for Resident #3.</p> <p>The findings include:</p> <p>Review of the facility policy Care Plan-Interdisciplinary (ITD) effective 01/08 revealed the facility provided care planning for each resident based on needs. The IDT were to review each care plan at least quarterly and as needed.</p> <p>1. Observation, on 01/03/12 at 8:20 PM, on 01/04/12 at 9:00 AM, 10:35 AM and on 01/05/12 at 8:45 AM, 9:20 AM, 10:30 AM, 10:50 AM and at 11:05 AM revealed Resident #3 in the bed with a fall mat propped upright against the wall.</p> <p>Clinical record review revealed the facility admitted Resident #3 on 12/14/11 and readmitted the resident on 01/02/12 with the diagnoses of Chronic Obstructive Pulmonary Disease and Pneumonia. The nurses' notes, dated 12/22/11, revealed the resident had sustained a fall. The facility determined that the resident needed a fall mat on the floor next to the bed when the resident was in bed and a clip alarm. The resident's care plan was updated to include the floor mat and the clip alarm on 12/22/11.</p>	F 282	<p>provided/being implemented according to the plan of care. Reviews will include fall mats and resident positioning during meals. The Director of Nursing and/or MDS Coordinator will report a findings of the care plan audit to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2-19-12 <i>per action</i> <i>by PB 2-13-12</i></p>	



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

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F 282	Continued From page 24 Interview, on 01/06/12 at 2:10 PM, with Certified Nurse Aide (CNA) #9 revealed the facility was to place a fall mat on the floor when the resident was in bed, however, she did not place the mat on the floor when she placed the resident in bed. Interview, on 01/06/12 at 2:40 PM with Licensed Practical Nurse (LPN) #8 revealed the resident required a fall mat on the floor next to the bed, however, she thought the Resident was to have the mat at night. She reported she did use the care plan. She stated (as she reviewed the care plan) the care plan did not say the fall mat was to be used at night only and should use the fall mat in the daytime, as well. 2. Review of the medical record for Resident #12, revealed the facility admitted the resident on 07/01/05 with diagnoses including Head Injury, Dysphasia, and Quadriplegia. Review of the quarterly Minimum Data Set (MDS) assessment completed by the facility on 10/19/11 and an annual MDS assessment on 07/01/11, indicated the facility was unable to determine cognition of Resident #12. The resident required extensive assistance with dressing, eating, hygiene and bathing. The Comprehensive Care Plan for	F 282			



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

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F 282	<p>Continued From page 25</p> <p>Resident #12 revealed the facility revised the care plan on 11/02/11 and added the potential for aspiration pneumonia related to the dysphasia. The facility staff fed the resident. The care plan instructed staff to position the resident at 70-90 degrees for oral intake.</p> <p>Review of the Dysphasia Evaluation for Resident #12 revealed, Speech Therapy was asked to see the resident after an episode of aspiration pneumonia on 03/23/11 and provided therapy including positioning instructions. At the initiation of services the baseline for positioning was forty-five (45) degrees. On 04/14/11 the status of the positioning was increased to eighty (80) degrees</p> <p>Interview with the Speech Therapist, on 01/06/12 at 10:45 AM, revealed she had worked with Resident #12 for risk of aspiration. She stated the resident should be up at least 70 degrees while eating to optimize safety. She stated she had worked with staff on proper positioning for Resident #12 in March 2011.</p> <p>Observation of Resident #12, on 01/05/12 at 12:35 PM, revealed the resident sitting in a reclined geri-chair while CNA #2 fed the resident.</p> <p>Interview with CNA #2, on 01/05/12 at 12:35 PM, revealed the resident's care plan required the resident to be sitting at a ninety (90) degree angle during feeding. She stated she just did not do it. She indicated the resident was in danger of aspiration in a reclined position.</p>	F 282		
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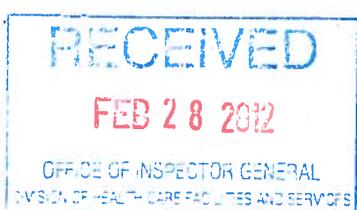
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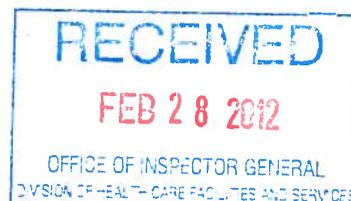
F 282	Continued From page 26 Interview with CNA #6 on 01/06/12 at 11:00 AM revealed she had provided care for Resident #12 and stated the resident should be positioned at ninety (90) degrees when receiving oral intake but it was difficult to do because of the contractures of the arms and neck. CNA #6 stated she was "scared" of Resident #12 when the resident was fed because the resident could choke.	F 282		
F 309 SS=E	Interview with the Director of Nursing, on 01/06/12 at 2:30 PM, revealed the resident's care plan should have been followed to prevent aspiration. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care: This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's policy on Physician/Prescriber Authorization and Communication of Orders to Pharmacy, it was determined the facility failed to follow Physician's Orders on one (1) of three (3) unsampled residents, Resident C. The facility sent Resident C to the hospital and then readmitted the resident with new orders. The facility failed to verify the new orders and failed to discontinue the previous orders. The facility failed to transcribe and implement Physician's Orders for two (2) of nineteen (19) sampled	F 309	F309 1. On 1/9/12 the Nurse Practitioner re-assessed Resident #1's heels and documented that heel boots were not indicated for Resident #1 at that time. Resident #8 was re-assessed by the Speech Therapist on 1/20 - 1/27/12 to determine current care needs and/or recommendations for care. There were no further recommendations at that time. Resident C's physician and responsible party were notified on 1/30/12 by the Licensed Nurse that the resident had received the additional doses of medication. Resident C had no documented adverse affects from the additional doses of medication. The physician had no additional orders for Resident C. 2. Review of current residents Physician Progress Notes and Speech Recommendations written during the last 30 days was completed by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisor by 2/5/12 to determine orders have been implemented and recommendations have been discussed with the physician and implemented as indicated. Review of current residents' physician orders compared to the Medication Administration Records and Treatment Administration Records was completed by	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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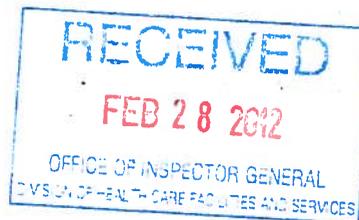
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F 309	<p>Continued From page 27</p> <p>residents, Resident #1 and #8. The facility failed to transcribe and implement physician orders for heel boots for Resident #1. In addition, the facility failed to notify the physician of recommendations made by the Speech Therapist for aspiration precautions for Resident #8 and the recommendations were not implemented.</p> <p>The findings include:</p> <p>The facility policy Physician/Prescriber Authorization and Communication of Orders to Pharmacy (Effective 12/01/07 and Revised 05/01/10) was submitted as the policy the facility followed to transcribe medication orders received from the physician. The policy stated the facility should verify and reconcile transfer and admission orders before they are communicated to the pharmacy.</p> <p>The facility did not have a policy on the transcription of Physician's Orders.</p> <p>1. Record review revealed Resident "C" had received Physician's Orders on 12/22/11 for Bactrim DS by mouth twice a day for ten days. The following day, 12/23/11, the physician ordered the Bactrim DS discontinued and ordered Doxycycline 100 mg, one pill by mouth twice a day for ten (10) days. Later that night, Resident "C" had a change in his/her medical condition which resulted in Resident "C" being transferred to the hospital and admitted. On 12/28/11</p>	F 309	<p>2/1/12 by the Licensed Nurse to determine that orders for medications or treatments were transcribed appropriately on administration records and implemented.</p> <p>3. Licensed Nurses were re-educated regarding following physician orders, transcribing orders, verifying orders and to notify the physician of recommendations made by other disciplines by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors. Therapy Staff were re-educated by the Administrator by 2/5/12 regarding inter-departmental communication. A letter regarding the process of flagging orders for the nurse's attention was faxed to attending physicians/physician extenders by the Administrator and Director of Nursing Services on 2/20/12. The Director of Nursing Services, Staff Development Coordinator, Unit Managers, Nursing Supervisors will review 24 Hour Reports, and new orders during clinical morning meeting to identify residents who have had a recommendation for care, or who have been seen by a physician or extender and further determine that recommendations and/or orders have been transcribed to be implemented as necessary.</p> <p>4. The Director of Nursing Services and/or Staff Development Coordinator will review</p>	



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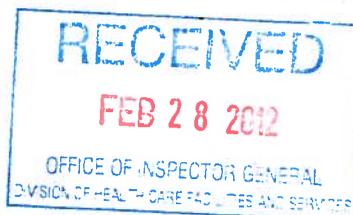
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359	
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F 309	<p>Continued From page 28</p> <p>Resident "C" was discharged from the hospital and readmitted to the facility with new orders. The orders contained a list of medications to be administered in the facility to the resident. The orders were not entered into the computer as an updated list of medications for Resident "C", resulting in Resident "C" continuing medications which had been discontinued. Specifically, Doxycycline was administered to the resident on 01/01/12 and 01/02/12 without an order. In addition, the Bactrim DS which had a discontinued order received on 12/23/11 was incorrectly started again on 01/02/12. The old orders were printed on the Medication Administration Record (MAR) generated for use starting 01/01/12. They had not been removed when the MAR was to be updated after Resident "C" returned from the hospital.</p> <p>Observation, on 01/04/12 at 9:35 AM, during the medication pass revealed Licensed Practical Nurse (LPN) #5 passing medications to Resident "C". The MAR listed Bactrim in the dose of 400-80 mg to be given daily by mouth. The medication was not available in the drawer. LPN #5 stated she initialed and circled the medication to indicate the medication was unavailable and not given at that time. However, the following day, the MAR revealed the medication had been administered on 01/06/12.</p> <p>Interview, on 01/06/12 at 10:10 AM, with LPN #5 revealed the medications for Resident "C" were in the computer system and when the change over for January (2012) took place, the MARs should have been checked against the Physician's</p>	F 309	<p>ten (10) resident physician orders, physician's progress notes, and/or other discipline recommendations weekly for four (4) weeks, then monthly for five (5) months to determine other discipline recommendations have been communicated to the physician and/or physician's orders have been transcribed, verified, and implemented. The Director of Nursing report results of the reviews to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>S. 2/24/12 2-19-12 per letter By PB 3-13-12</p>	



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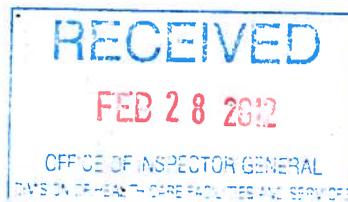
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/06/2012
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359		
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F 309	<p>Continued From page 29</p> <p>Orders. She stated when the orders were not checked it caused the Doxycycline and Bactrim orders to again show up on the MAR. It was revealed the 200 Hall did not have a Unit Manager at present and the Unit 100 Nurse Manager had been helping with checking the MARs. She revealed the lack of checking the current orders could cause serious consequences to the resident such as a drug reaction, serious illness or death.</p> <p>Interview, on 01/06/12 at 1:05 AM, with LPN #4 revealed when a resident returned from the hospital to the facility the Unit Manager reviews the orders and double checks them. Then another nurse goes through the new orders and checks them. It was revealed once a month the MAR's were checked by the Unit Manager; however, the 200 Hall where Resident "C" lived, currently did not have a Unit Manager. She stated without a Unit Manager doing the MAR checks, and the unit nurses being too busy to check the new MAR's, it was the responsibility of the Director of Nurses to verify orders against the MAR for the new month. (The facility refers to this as "change over".)</p> <p>Interview, on 01/06/12 at 2:10 PM, with the 100 Hall Unit Manager revealed the new orders that were put in the computer were verified by the nurses. She stated that was the process for new admits and readmits. She did not know what training staff was given to verify Physician's Orders against the MAR.</p>	F 309			



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 309	<p>Continued From page 30</p> <p>Interview, on 01/06/12 at 3:06 PM, with the Director of Nursing revealed there was a breakdown in the system for transcribing Physician's Orders and following the orders.</p> <p>2. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 03/02/11 with diagnoses of Diabetes and Hypertension. On 04/07/11, the facility completed a Speech Therapy Evaluation which revealed the resident had decreased bolus control (swallow) when taking large bites of food or drinking a large amount of fluid. The Speech Therapist recommended the resident take small bites, small sips of liquids and keep a level chin during meal time. In addition, the therapist recommended standard reflux precautions and for the resident to be sitting at 90 degrees of elevation while eating or drinking.</p> <p>Review of the comprehensive care plan, revealed Resident #8 experienced respiratory infections and breathing difficulties on occasion, however, there was no documentation located to provide evidence the facility planned to implement the recommendations or monitor the resident during meals to prevent aspiration. The facility treated the resident for pneumonia 10/24/11.</p> <p>Observation of Resident #8, on 01/04/12 at 12:20 PM and on 01/05/12 at 12:25 PM, revealed the resident being served and eating meals in the main dining room. The resident was observed, at both meals, to bow his/her head while chewing and swallowing and to ingest large bites of food,</p>	F 309		



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

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F 309	<p>Continued From page 31</p> <p>The facility staff did not Intervene or provide reminders or culing to the resident during these meals.</p> <p>Interview with Certified Nurse Aides (CNA) #4 and #2, on 01/05/11 at 1:00 PM, revealed they were not aware Resident #8 had problems with swallowing. They stated they did not monitor the amount of food the resident placed in his/her mouth or know what reflux precautions were.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/05/12 at 1:20 PM, revealed the resident had episodes of respiratory infections, however, she had no knowledge of a Speech Therapy Evaluation for Resident #8 completed on 04/07/11. She stated the resident's care plan, by the Minimum Data Set (MDS) Coordinator, did not address any swallowing problems/precautions for the resident. She stated the information should be on the resident's care plan.</p> <p>Observation of Resident #1, on 01/04/12 at 9:30 AM, revealed the resident resting in bed on his/her back on a speciality mattress. His/her feet were at the end of the bed, with minimal space (Inches) between the foot board and the resident's feet. The feet and heels were not floated or elevated. The resident could not answer questions, but did open eyes. The head of the bed was elevated. The resident had a tube feeding at 65 milliliters per hour per G-Tube, and a Tracheostomy with a Trach mask administering oxygen at 40%. There were no heel pressure relieving boots on the resident or in the room.</p>	F 309			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

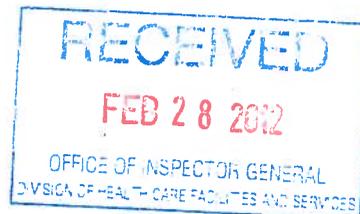
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40358
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F 309	<p>Continued From page 32</p> <p>3. Observation of Resident #1, on 01/04/12 at 11:45 AM, during a skin assessment and wound care by LPN #8, revealed a 1.0 centimeter (cm) by 1.0 cm unstageable pressure ulcer to right lateral heel with eschar and a newly discovered pressure ulcer on the left medial heel which measured 1.0 cm by 0.8 cm purple area.</p> <p>Continued observation of Resident #1, on 01/04/12 at 10:45 AM, 11:45 AM, 3:00 PM, 4:00 PM, and 4:15 PM, revealed the resident in bed, the head of the bed was elevated and feet were at the end of the bed. The feet and heels are not floated or elevated. The resident did not have heel pressure relieving boots in use.</p> <p>Review of Physician orders for Resident #1 revealed on 12/14/11 the Vascular Surgeon visited the resident and wrote a consult note that included recommendations for heel boots/pads. On 12/22/11 the Vascular Surgeon visited and recommended heel pressure relief boots. The orders were not dated or signed off by facility staff.</p> <p>Interview with the Vascular Surgeon on 01/06/12 at 1:30 PM revealed he had consulted on Resident #1. He stated he told "a nurse" about the heel boots recommendation. He stated he did not know the resident had not received the heel boots.</p> <p>Interview with Licensed Practical Nurse #8 on 01/06/12 at 1:45 PM revealed she worked both</p>	F 309		
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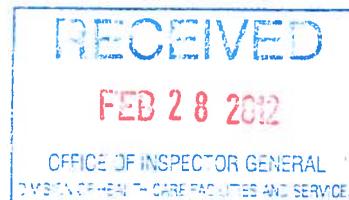
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F 309	Continued From page 33 days the orders were received but denies she ever seen or new the vascular surgeon had written orders. Interview with the 100 Unit Manager, on 01/06/12 at 2:30 PM, revealed she did talk with the Vascular Surgeon on 12/14/11 about Resident #1 and viewed the "big long note" the physician wrote but it was the responsibility of the floor nurse to take off physician orders. She stated there was a Physician orders system failure and she didn't know what happened but the only thing Resident #1 didn't get was the heel boots. She stated it was everyone's responsibility to make sure the resident got the proper equipment.	F 309	F314 1. On 1/9/12 the Nurse Practitioner re-assessed Resident #1's heels and documented that heel boots were not indicated for Resident #1 at that time. Betadine paint and to float heels on pillows, were ordered for Resident #1, and orders have been carried out as written. Resident #1 was provided with an alternate bed on 1/5/12 by the nurse.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents did not develop pressure ulcers for one (1) of nineteen (19) sampled residents. Resident #1 developed pressure ulcers on the left and right heels. In addition, the facility failed to implement a	F 314	2. Skin assessments were completed for current residents by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors by 2/5/12. Rounds were completed by the Administrator, Director of Nursing Services, Restorative Aide, Therapy Program Manager, Unit Managers, Social Services Director and Central Supply by 2/2/12 to review that current residents had preventative measures in place as needed to assist in the prevention of skin breakdown. Physician orders of current residents were reviewed by 2/1/12 by Licensed Nurses to determine orders were implemented. 3. Re-education for Licensed Nurses and Certified Nursing Assistants was completed by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors. Education includes the Skin Care and	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 34</p> <p>physician's order for the use of heel boots after the Vascular Surgeon made two (2) visits and made recommendations on both visits for the heel boots.</p> <p>The findings include:</p> <p>Review of the facility's policy Skin Care and Pressure Ulcer Management Program, revised 01/11, revealed the facility used the Assess, Plan, Implement, and Evaluate approach to care giving. The facility was to assess the resident to identify if the resident was at risk for skin breakdown daily, weekly, monthly, and quarterly according to the Minimum Data Set (MDS) assessment schedule. The licensed nurse continued the evaluation process to determine the risk for additional skin breakdown. Any new skin issue was an "incident" which required an investigation to determine the root cause as part of the investigation process. Through the performance improvement investigation process, information is gathered to determine why the resident may have developed a pressure ulcer. Even if the pressure ulcer was "avoidable", it was necessary to determine why it happened and make changes to avoid future occurrences.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 03/30/11 with diagnoses including Tracheotomy, Aphasia related to Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease, Gastronomy Tube, Insulin Dependent Diabetes, and Chronic Respiratory Failure. The facility</p>	F 314	<p>Pressure Ulcer Management Program, implementing physician orders, and utilizing the 24 Hour Report to communicate resident care needs to the interdisciplinary team.</p> <p>4. The Director of Nursing Services, Staff Development Coordinator and/or Unit Managers will complete rounds weekly for four (4) weeks, then monthly for five (5) months to determine preventative measures are in place as needed to assist in the prevention of skin breakdown, to include bed length. The Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors will complete center-wide skin assessments on center residents monthly for six (6) months to determine treatment and services to prevent/heal pressure sores are implemented. The Director of Nursing Services will report results of rounds for preventative measures and skin assessments to the Performance Improvement Committee meeting monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2-19-12 per action by PB 3-12-12</p>	



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F 314	<p>Continued From page 36</p> <p>completed an admission Minimum Data Set (MDS) assessment, dated 04/08/11, and a quarterly MDS assessment, dated 12/02/11. These assessments revealed Resident #1 required extensive assistance with two person physical assist for transfers, was unable to speak, and functional limitations of range of motion were present on both sides, including the upper and lower extremities. Review of the Comprehensive Care Plan, initiated on 04/12/11, revealed the facility developed a care plan for potential skin breakdown related to immobility syndrome and a history of CVA with interventions that included: Pressure relieving/ reducing devices, low air loss mattress, requires two assist with bed mobility, bathing, incontinence care and to turn and reposition every two hours; however, there was no evidence the facility identified a concern with the resident's height exceeding the length of the bed.</p> <p>Review of the Pressure Ulcer Documentation Form for Resident #1 revealed it was initiated on 12/04/11 when the facility identified a "hematoma" on the right heel measuring 1.0 centimeters (cm) by 1.3cm. The Physician was notified and orders were received. On 12/08/11, the facility assessed the wound to the right heel as a 1.0cm by 1.3cm unstageable pressure ulcer with 100% eschar. Orders were received to float the resident's heels and to consult a wound/vascular specialist.</p> <p>Review of the Vascular Surgeon consult notes, on 12/14/11, revealed the Surgeon assessed the</p>	F 314			



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

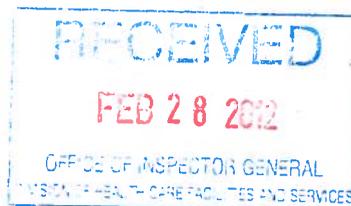
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F 314	<p>Continued From page 36</p> <p>wound as a 1.0 cm by 1.0 cm pressure ulcer with a "dark area" to the right heel with no redness, no ulceration, positive for pedal pulses, posterior tibia pulses, femoral and popliteal pulses. His recommendations were for conservative treatment, use of protective heel boots/pads, keep the area dry, betadine paint to the area, and no debridment at this point. Review of the consult notes on 12/22/11 revealed he assessed the wound to the right heel as approximately 1cm by 1cm "necrotic heel ulcer" with recommendations for heel pressure relief boots and betadine paint to the ulcerated area daily.</p> <p>Interview with the Vascular Surgeon, on 01/06/12 at 1:30 PM, revealed he was told by nursing the cause of the pressure ulcer to the right heel of Resident #1 was a brace that was improperly applied and that the therapy department was "re-doing" the brace. He stated he had recommended the pressure relieving boots and "told a nurse" at the nurses station when he wrote the orders. He stated he did not know the order had not been implemented. He stated it was definitely possible for pressure ulcers to occur if the resident's feet are hitting against the foot board.</p> <p>Review of the Pressure Ulcer Documentation Form for Resident #1, revealed on 12/17/11 the facility assessed the wound to the right heel as an unstageable pressure ulcer and the ulcer measured 1.7 cm by 0.9 cm with 100% eschar. On 12/23/11, the facility assessed the wound as an unstageable pressure ulcer measuring 1.4 cm by 0.9 cm with 100% eschar. On 12/30/11, the</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

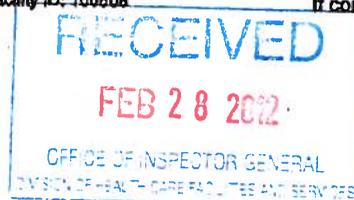
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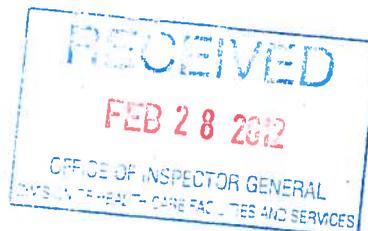
F 314	<p>Continued From page 37</p> <p>facility assessed the wound as measuring 1.0 cm by 1.0 cm unstageable pressure ulcer with 100% eschar.</p> <p>Observation of Resident #1, on 01/04/12 at 9:30 AM, revealed the resident resting in bed on his/her back on a speciality mattress. His/her feet were at the end of the bed, with minimal space (Inches) between the foot board and the resident's feet. The feet and heels were not floated or elevated. The resident could not answer questions, but did open eyes. The head of the bed was elevated. The resident had a tube feeding at 65 milliliters per hour per G-Tube, and a Tracheostomy with a Trach mask administering oxygen at 40%. There were no heel pressure relieving boots on the resident or in the room.</p> <p>Observation, on 01/04/12 at 11:45 AM, of the skin assessment and wound care completed by LPN #8 revealed, a 1.0 cm by 1.0 cm unstageable pressure ulcer to right lateral heel with eschar and a newly discovered pressure ulcer on the left medial heel which measured 1.0 cm by 0.8 cm purple area.</p> <p>Continued observation of Resident #1, on 01/04/12 at 10:45 AM, 11:45 AM, 3:00 PM, 4:00 PM, and 4:15 PM, revealed the resident in bed, the head of the bed was elevated and feet were at the end of the bed. The feet and heels are not floated or elevated. The resident did not have heel pressure relieving boots in use.</p>	F 314		
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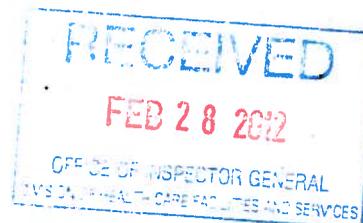
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F 314	<p>Continued From page 38</p> <p>Observation, on 01/05/12 at 8:30 AM, of Resident #1 revealed staff in the room in the process of getting the resident up to a recliner chair. The resident did not have heel boots on at this time.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 01/05/12 at 5:10 PM, revealed she had provided care for Resident #1 occasionally, and the resident was total care with bathing, and turning. She stated she had never witnessed the resident have any voluntary movements of the extremities.</p> <p>Interview with CNA #4, on 01/05/12 at 5:15 PM, revealed she had provided care to Resident #1 on a regular basis and the resident was total care with no voluntary movement of the extremities. She stated the staff would have to constantly lift the resident up in the bed to keep the resident's feet off of the foot board. She stated they had reported this to the nurses several times and they should have known.</p> <p>Interview with CNA #5, on 01/05/12 at 5:20 PM, revealed she had provided care for Resident #1 on a regular basis. She stated the resident was total care with bathing, turned every two hours, and the resident had no voluntary movements of the extremities. CNA #5 stated they had to "constantly" lift the resident up in the bed because the resident was so tall and on a speciality air mattress, just to keep the residents feet from touching the foot board.</p> <p>Interview with the 100 hall Unit Manager,</p>	F 314			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/06/2012
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
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F 314	<p>Continued From page 39</p> <p>Licensed Practical Nurse (LPN) # 8, on 01/04/12 at 4:00 PM, revealed Resident #1's bed was not long enough for the resident and she stated that could cause pressure and skin breakdown, because the resident's feet either came in contact with the foot board or were hanging over the foot board.</p> <p>Interview with the Occupational Therapist Registered/Licensed (OTR/L), on 01/06/12 at 1:00 PM, revealed the resident was discontinued from services on 12/01/11 with heel lift boots in use without any difficulty and no pressure ulcers present. She stated she had reported to staff many times Resident #1's feet were against the foot board and the resident had to be pulled up in the bed.</p> <p>Interview with the Therapy Director, the OTR/L, and the 100 Unit Manager, on 01/06/12 at 2:55 PM, revealed the heel lift boots used for Resident #1 were not the kind that you could modify. The Therapy Director and OTR/L stated they were only told by nursing that the heel lift boots were discontinued and removed from the resident's room because nursing believed the heel lift boots caused the wound to the right heel. The Therapy Director and OTR/L went on to say they had no knowledge of any new orders for heel pressure relief boots.</p> <p>Interview with the Director of Nursing, on 01/06/12 at 3:00 PM, revealed there was a potential complications of skin breakdown if the resident was not in a bed big enough.</p>	F 314			



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

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F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to store foods under sanitary conditions. Supplies delivered on 01/03/12 were still boxed and stacked on the floor in the storage room and left to be put away on 01/04/12. Flour, sugar and corn meal were stored in bags open and in bins with lids that were cracked and broken preventing the bins from being sealed closed. In addition, facility staff were not using proper hand washing techniques while serving meals to residents in the 200 dining room.</p> <p>The findings include: Review of the facility's policy Food Storage-Dry, effective 07/08, revealed all dry goods will be appropriately stored in accordance with guidelines of the USDA Food Code. Action #1 stated to store all items 6 inches above the floor on shelves, racks ...</p> <p>Observation, on 01/03/12 at 7:35 PM, revealed</p>	F 371	<p>F371</p> <p>1. The dry food supplies were stocked on 1/4/12 by Nutritional Services staff. Replacement bins for the flour, sugar, and corn meal bins were put in service on 1/30/12 by the Nutritional Services Director. Re-education was provided to the Social Services Director on 1/30/12 by the Director of Nursing Services and/or Staff Development Coordinator regarding hand washing procedures. Re-education was provided to CNA #10 on 1/30/12 by the Director of Nursing Services and/or Staff Development Coordinator regarding hand washing procedures.</p> <p>2. An inspection of the kitchen was completed on 1/31/12 by the Dietician and Nutritional Services Director to determine staff store, prepare, distribute and serve food under sanitary conditions. Any issues identified were corrected.</p> <p>3. Dietary Aides and Cooks were re-educated by 2/5/12 by the Nutritional Services Director regarding sanitation in the kitchen, and food and kitchen supply storage in a sanitary manner. Administrative Staff, Nursing Staff, Housekeeping Staff, Maintenance Staff, Dietary Staff and Therapy Staff were re-educated on proper hand washing</p>	



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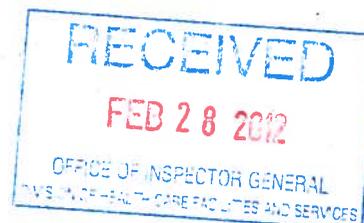
F 371	<p>Continued From page 41</p> <p>sixteen (16) boxes stored on the floor in the food storage room. There were two (2) bags of flour with boxes of food on the floor.</p> <p>Interview with Dietary Staff #1, on 01/03/12 at 7:35 PM, revealed the delivery of supplies was made at 12:30 PM that day with the dietary staff stating it was the Dietary Manager's responsibility to put away the supplies.</p> <p>Observation, on 01/05/12 at 11:15 AM, revealed three (3) bins with flour, sugar and cornmeal in open bags in the bins. All three (3) bins had lids that were cracked and broken. None of the bins were completely sealed and had holes around the edges of the lids.</p> <p>Interview with the Dietary Manager, on 01/05/12 at 11:15 AM, revealed she had requested new bins about one month ago. She stated the bins having lids that were not sealed and open bags that there was a potential for bugs to get in.</p> <p>Review of the facility policy for Hand Hygiene, dated April 2011, revealed hands should be washed for at least fifteen (15) seconds and a paper towel should be used to turn off the water faucet.</p> <p>Observation of the meal service in the 200 Hall Dining Room, on 01/05/12 at 12:21 PM, revealed facility staff preparing to serve meals to residents. The Social Services Director (SSD) used the sink in the dining room to wash her hands. She was observed to wash her hands for eight (8) seconds, rinsed with water, then turned the water</p>	F 371	<p>procedures by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors.</p> <p>4. The Nutritional Services Director will complete sanitation audits of the kitchen once weekly for four (4) weeks, then twice monthly for two (2) months, then monthly for three (3) months. The Nutritional Services Director will report audit findings to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. The Staff Development Coordinator will complete hand washing skills audits with four (4) at random employees weekly for four (4) weeks, then four (4) at random employees monthly for five (5) months. The Staff Development Coordinator will report results of the hand washing skills audit to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2-19-12 <i>per audit</i> by PIB 3-13-12</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 42 faucet off with bare hands. Observation of Certified Nurse Aide (CNA) #10, on 01/05/12 at 12:23 PM, revealed she washed her hands with soap and water for six (6) seconds, rinsed then turned the water faucet off with her bare hands. Interview with the SSD, on 01/05/12 at 2:00 PM, revealed she was not aware she had turned the water faucet off with her bare hands or not washed her hands long enough. She stated she had been trained to turn the faucet off with a paper towel and to wash her hands for fifteen (15)seconds. Interview with CNA #10, on 01/05/12 at 2:10 PM, revealed she had been trained on hand washing and hands should be washed for fifteen (15) seconds and the water faucet turned off using a paper towel. Interview with the Director of Nursing, on 01/06/12 at 2:30 PM, revealed all staff had been trained to wash their hands for fifteen (15) to thirty (30) seconds and to turn the water faucet off with a paper towel.	F 371			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431			



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

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F 431	<p>Continued From page 43 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and the facility's policy for Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, it was determined the facility failed to store all drugs and biologicals in accordance with currently acceptable professional principles. Biological's were not dated when opened on four (4) of four (4) treatment carts. In addition, the facility failed to separately store oral medications, injectables,</p>	F 431	<p>F431</p> <ol style="list-style-type: none"> 1. The undated open bottles were removed and discarded from the 100 hall, & 200 hall treatment carts on 1/6/12 by the Licensed Nurse. The 100 hall & 200 hall medication carts were cleaned and organized to separately store oral medications, injectables, topicals, and inhalants by the Licensed Nurse on 1/6/12. 2. Each medication cart, treatment cart, and medication room was inspected by the Unit Managers on 1/27/12 for undated opened bottles and proper medication storage. Any identified issues were addressed. 3. Licensed Nurses and Kentucky Medication Aides were re-educated by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisor by 2/5/12 on medication labeling and storage. 4. The Director of Nursing Services, Staff Development Coordinator, Unit Manager, and/or Nursing Supervisor will audit the medication carts, treatment carts and medication rooms weekly for four (4) weeks, then twice monthly for five (5) months to determine opened bottles are dated and medications are stored appropriately. The Director of Nursing Services will report findings of audit to the 	
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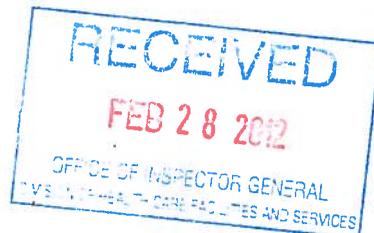
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F 431	<p>Continued From page 44</p> <p>topical medications and inhalants in three (3) of four (4) medication carts.</p> <p>The findings include:</p> <p>Review of the facility policy Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles (Effective 12/01/07, Revised 08/09/11) revealed the facility should ensure that external use medications and biological's were stored separately from internal use medications and biological's. The policy further stated the facility should record the date opened on the medication container.</p> <p>Observation, on 01/05/12 at 10:00 AM, of the 200 Hall treatment carts revealed both carts had Skin Integrity Wound Cleanser opened and undated in the bottom of the cart. The short hall contained three (3) undated open bottles and the long hall contained two (2) undated open bottles.</p> <p>Observation, on 01/06/12 at 9:30 AM, of the 100 Hall treatment carts revealed the long hall cart had two (2) Integrity Wound Cleanser opened and not dated and a Dermal Wound Cleanser opened and not dated. In addition, the short hall cart had four (4) Integrity Wound Cleanser bottles open and not dated.</p> <p>Observation, on 01/06/12 at 10:00 AM, of the 200 Hall medication carts revealed two (2) of the two (2) medication carts did not separate oral medications from medications that were administered by another route. One cart had</p>	F 431	<p>Performance Improvement Committee monthly for six (6) months for further review and recommendation</p> <p>5.2/24/12 2/19/12 per Acta.</p> <p>by RB 3-13-12</p>	



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F 431	<p>Continued From page 45</p> <p>Fortical Nasal Spray and Fluticasone Propionate Nasal Spray stored together with Robafen liquid, Guaifenesin DM liquid and Oxcarbazepine oral suspension. The other cart contained hydrocortisone topical cream stored together with oral Polyethylene Glycol powder, an oral solution.</p> <p>Observation, on 01/06/12 at 9:30 AM, of the 100 Hall medication carts revealed one (1) of two (2) medication carts did not separate oral medications from medications that were administered by another route. One cart contained Fortical Nasal Spray stored with oral medications, to include Guaifenesin DM and five other oral liquid medications. In addition, the cart contained injectable Enoxaparin Sodium stored with liquid Valproic Acid 250 mg/5 ml syrup and five (5) other liquids. Also two (2) Enema ready to use were stored with oral liquid Tylenol.</p> <p>Interview, on 01/08/12 at 8:55 AM, with Licensed Practical Nurse #1 revealed she was not aware medications needed to be stored separately based on the route of administration. She stated she did know biological's were to be dated when opened.</p> <p>Interview, on 01/06/12 at 2:10 PM, with the 100 Unit Manager revealed the nurses using the medication carts were responsible to monitor the carts for appropriate storage of medications. She revealed medications were stored together based on their route of administration. It was stated pharmacy did a monthly review of the medication carts.</p>	F 431			



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

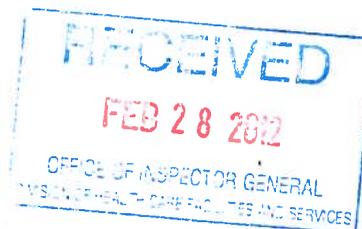
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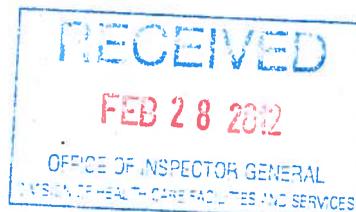
F 431	Continued From page 46 Interview, on 01/06/12 at 2:20 PM, with Staff Development revealed he did not know who trained the staff about the storage of medications. Interview, on 01/06/12 at 2:45 PM, with LPN #4 revealed the nurses monitored the medication carts for correct placement of medications. She stated it was a team effort.	F 431		
F 441 SS=E	483.85 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 (3) Maintains a record of incidents and corrective actions related to infections.	F 441		



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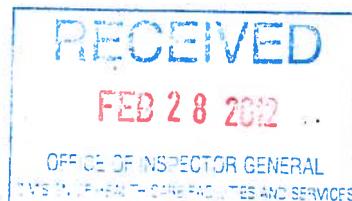
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F 441	<p>Continued From page 47</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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, interviews, and facility policies, it was determined the facility failed to maintain an Infection Control Program to ensure a safe and sanitary environment to help prevent development and transmission of disease and infection. Oxygen equipment and indwelling catheter tubing/bags were found in contact with the floor. Oxygen tubing was not routinely changed per the facility's policy. Poor handwashing or no handwashing was observed by staff providing indwelling catheter care and skin assessments. Privacy curtains were contaminated by staff wearing soiled gloves. Hand washing was not noted after a nurse picked</p>	F 441	<p>F441</p> <p>1. The oxygen tubing and mini-neb tubing for resident #1 was replaced on 1/6/12 by the Licensed Nurse. The nasal oxygen tubing for resident #3 was replaced on 1/6/12 by the Licensed Nurse. The foley catheter tubing was removed from the floor for residents' #9, & #4 on 1/6/12 by the Certified Nurses Assistant. Resident #9's privacy curtain was removed and replaced with laundered curtain on 1/26/12 by the Housekeeper.</p> <p>Re-education was completed regarding changing gloves, hand washing, tubing touching the floor, and completing head to toe assessments with LPN#5 on 1/31/12 by the Director of Nursing Services and/or Staff Development Coordinator. Re-education was completed regarding changing gloves, hand washing, and tubing touching the floor with CNA #1 on 2/1/12 by the Director of Nursing Services and/or Staff Development Coordinator. LPN #8 is no longer employed by the center.</p> <p>2. Rounds were completed on 2/1/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors to determine disposable oxygen equipment was dated, changed and stored appropriately, staff were performing hand washing appropriately, and privacy curtains inspected for need to be</p>	



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359	
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F 441	<p>Continued From page 48 up a pill from the floor. In addition, nurses conducted skin assessments from toe to head, without using hand hygiene, instead of performing the assessment from head to toe.</p> <p>The findings include:</p> <p>Review of the facility's policy for Hand Hygiene Skills, dated April 2011, revealed that gloves do not replace the need to hand wash and when washing hands with water and soap, rub hands together for at least fifteen (15) seconds. Hands should be washed after contact with contaminated items/areas.</p> <p>Review of the facility's policy for Skin Assessment, dated 09/11, revealed the nurse will perform a head-to-toe assessment as directed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/06/12 at 2:45 PM, revealed the facility had a contracted company that came to the facility weekly and weekly changed out all disposable oxygen equipment. She stated sometimes the night shift changed the tubing out. She stated she couldn't believe the oxygen tubing was dated 11/04/11. She also stated that if oxygen tubing was on the floor it should be discarded.</p> <p>Interview with the Director of Nursing, on 01/06/12 at 3:00 PM, revealed staff should know to dispose of any respiratory equipment that was found on the floor.</p> <p>Interview, on 01/06/12 at 4:10 PM, with the Nurse Consultant for the facility, revealed the nursing</p>	F 441	<p>cleaned. Residents with an indwelling catheter were reviewed on 1/6/12 by the Director of Nursing Services, Staff Development Coordinator, Central Supply Clerk and/or Unit Managers to determine catheters were properly secured and not making contact with the floor. Any identified concern was addressed.</p> <p>3. Infection Control re-education was completed with Licensed Nurses and Certified Nursing Assistants by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisor. Education included hand washing procedure, glove usage, head to toe skin assessment procedure, disposable oxygen equipment dating, changing, and storage, securing catheter tubing to prevent tubing from making contact with the floor and the responsibility to not touch privacy curtains in a manner that could contaminate them, and to report privacy curtains that were in need of being cleaned to Housekeeping.</p> <p>4. Infection Control rounds will be completed by the Staff Development Coordinator and/or Unit Managers weekly for four (4) weeks, then twice monthly for two (2) months, then monthly for three (3) months to determine center is maintained in a safe, sanitary environment. Rounds will include dating, changing, and storage of</p>	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359
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F 441	<p>Continued From page 49</p> <p>staff had access to the 6th edition of Clinical Nursing Skills & Techniques by Perry and Potter according to facility policy and facility policy for hand hygiene.</p> <p>Review of the 6th edition of Clinical Nursing Skills & Techniques by Perry and Potter, chapter 8 page 192 on Hand Hygiene revealed when moving from a contaminated body site to a clean body site during care, before and after contact with residents skin, and after contact with inanimate objects (such as medical equipment), hand hygiene should be performed.</p> <p>Observation, on 01/05/12 at 9:25 AM, revealed Resident #9 had an indwelling catheter. LPN #5 was observed applying gloves to both hands without washing her hands prior to resident contact. During the skin assessment it was revealed LPN #5 did not perform the head to toe skin assessment, but rather she started with the feet and assessed up to the head. LPN #5 assessed the peri-anal by touching the skin in the peri-anal area. The nurse continued to assess the resident by inspecting the skin and touching from the abdomen up to the head. LPN #5 was observed touching the resident's blanket and bed while wearing the same gloves used for the toe to head assessment. LPN #5 did not discard her gloves and wash her hands after touching the peri-anal area.</p> <p>Interview, on 01/06/12 at 09:25 AM, with LPN #5 revealed she was to use standard precautions with every resident contact where hands could come in contact with secretions. She stated she wore gloves while giving care and after giving</p>	F 441	<p>disposable oxygen equipment, catheters are secured to prevent tubing from making contact with the floor, and privacy curtains are clean. The Staff Development Coordinator will complete hand washing skills audits with four (4) at random employees weekly for four (4) weeks, then four (4) at random employees monthly for five (5) months. The Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors will complete skin assessment technique audits weekly for four (4) weeks, then twice monthly for two (2) months, then monthly for three (3) months. The Staff Development Coordinator will report findings of the Infection Control rounds, handwashing skills audits, and skin assessment technique audits to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p><i>5. 2/24/12 2-19-12 per Edm by RB 3-13-12</i></p>	
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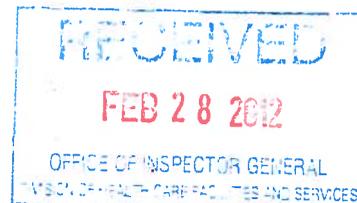
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359
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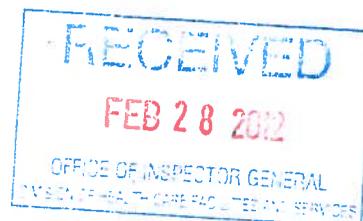
F 441	<p>Continued From page 50</p> <p>care she would remove those gloves and wash her hands for thirty (30) seconds or use hand sanitizer if her hands were not visably soiled. LPN #5 acknowledged not washing her hands prior to the skin assessments with Resident # 4 and #9. LPN #5 revealed she was aware of her toe to head assessment but was unaware of touching Residents #9 peri-anal area without removing her gloves and washing her hands as she continued with the skin assessment.</p> <p>Observation, on 01/05/12 at 8:25 AM, revealed Resident #9 was provided indwelling catheter care by CNA #1. She was observed cleaning around the resident's catheter with a gloved hand and then she pulled back the resident's privacy curtain with her gloved hands to walk toward the sink to retrieve more wash clothes. The CNA returned to the resident and provided peri-anal care. CNA #1 was observed adjusting the resident in the bed, adjusting the resident's indwelling catheter tube over his/her knee, and adjusting the resident's oxygen tubing without changing gloves.</p> <p>Interview, on 01/06/21 at 09:15 AM, with CNA #1 revealed the facillity policy on hand washing and glove changing was to wash hands before any resident contact or putting on gloves. CNA #1 stated she received training on hand washing about two (2) months ago. She acknowledged she had touched Resident #9's privacy curtain with dirty gloves then provided more resident care without changing her gloves. She stated she should have changed her gloves and washed her hands.</p> <p>Observation, on 01/05/12 at 10:00 AM, of LPN</p>	F 441		
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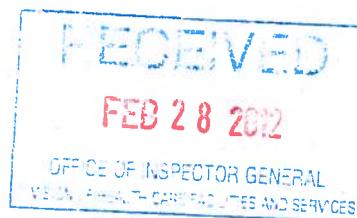
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F 441	<p>Continued From page 51</p> <p>#6's handwashing, after completing a skin assessment for Resident #4 revealed a hand washing time of seven (7) seconds and her hand washing time for Resident #9 was for six (6) seconds.</p> <p>Observation, on 01/04/12 at 3:15 PM, revealed Resident #9 in her room, sitting in his/her wheel chair; the indwelling catheter tubing was lying on the floor.</p> <p>Observation, on 01/05/12 at 12:20 PM, revealed Resident #9 in the hall next to nursing station unit 200 sitting in his/her wheelchair with indwelling catheter tubing lying on the floor.</p> <p>Observation, on 01/05/12 at 3:00 PM, revealed Resident #9 in his/her room watching television in his/her wheelchair with the indwelling catheter tubing touching the floor.</p> <p>Interview, on 01/06/12 at 2:30 PM, with CNA #1 revealed it was the policy to keep indwelling catheter tubing up off the floor to prevent infection. CNA #1 confirmed she was assigned to provide care to Resident #9 on 01/05/12 and 01/06/12.</p> <p>Observation, on 01/04/12 at 12:10 PM, revealed Resident #4 sitting in his/her wheelchair in the central dining room, at lunch time, with an indwelling catheter bag covered with the catheter tubing laying on the floor.</p> <p>Observation, on 01/04/12 at 12:55 PM, revealed Resident #4 sitting in his/her wheelchair, propelling independently back from lunch and the indwelling catheter tubing was dragging the floor.</p>	F 441			



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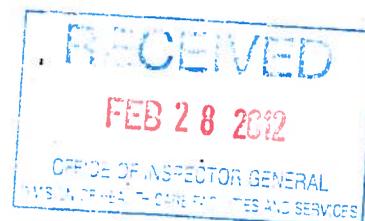
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F 441	Continued From page 52 Interview, on 01/06/12 at 2:30 PM, with CNA #1 revealed it was the policy to keep indwelling catheter tubing up off the floor to prevent infection. Interview, on 01/06/12 at 2:45 PM, with LPN #5 revealed that indwelling catheters must not touch the floor and the risk to the resident includes infection and contamination. Interview, on 01/06/12 at 3:40 PM, with Director of Nursing (DON), revealed it was not appropriate for indwelling catheter tubing to be touching the floor, all facility staff should be washing their hands for 15 to 30 seconds before and after contact with residents along with putting on and taking off gloves. Observation of Resident #3, on 01/04/12 at 9:00 AM and 10:52 AM and on 01/06/12 at 9:27 AM and at 10:00 AM, revealed the resident's nasal oxygen tubing was on the floor. Interview with CNA #9, on 01/06/12 at 2:10 PM, revealed the nasal oxygen tubing was not to be left on the floor while in use on the residents. She reported the nasal oxygen tubing can be a potential for infection. Observation of LPN #8, on 01/04/11 at 10:40 AM, revealed she completed a toe to head skin assessment on Resident #6. She donned gloves and started at the resident's feet and proceeded up the body. She released the resident's adult	F 441			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 53</p> <p>brief and examined the resident's buttocks and perineum. She changed gloves; however, did not wash her hands between glove change.</p> <p>Interviewed of LPN #8, on 01/06/12 at 2:45 PM, revealed nasal oxygen tubing for Resident #3 was not to be left on the floor. She reported the potential for respiratory infections was a concern for the resident. She reported she should have started at the head of Resident #6, in the clean area and moved down toward the resident's feet and wash her hands between glove change. She stated the covers were down and she started at feet to be able to cover up the resident sooner.</p> <p>Observation, on 01/04/12 at 9:30 AM, 10:30 AM and 4:15 PM, revealed Resident #1 resting in bed. The resident had a Tracheostomy with oxygen per a trach mask at 40% dated 01/02/12. The oxygen tubing connected to the concentrator was dated 11/04/11. The mini- nebulizer tubing was dated 12/29/11 and was found on the floor.</p> <p>Observation, on 01/05/12 at 10:00 AM and 11:20 AM, revealed Resident #1's mini-nebulizer still dated for 12/29/11. The oxygen tubing connected to the oxygen concentrator was still dated 11/04/11. The resident's indwelling catheter bag was noted to be in contact with the floor.</p> <p>Observation, on 01/06/12 at 2:45 PM, revealed Resident #1's mini-nebulizer still dated for 12/29/11. The oxygen tubing connected to the oxygen concentrator was still dated 11/04/11.</p> <p>Observation, on 01/04/12 at 9:26 AM, revealed</p>	F 441			



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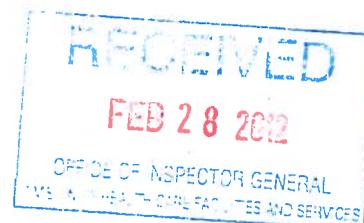
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<p>F 441</p> <p>F 465 SS=E</p>	<p>Continued From page 54</p> <p>LPN #5 passing medications. LPN #5 was observed to pick up a pill off the floor that a resident had spit out. LPN #5 charted the incident and moved to the next resident to administer medications. After the next resident received their medication, LPN #5 used hand gel to sanitize her hands, however, she did not sanitize or wash her hands prior to the administration of medication to the resident who received medication after she picked up the pill off the floor.</p> <p>Interview, on 01/04/12 at 9:40 AM, with LPN #5 revealed she did not wash or sanitize her hands after picking up the pill off the floor and moving on to the next resident to administer medication. She revealed she knew she was to sanitize her hands between residents receiving medications.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain seventeen (17) of forty (40) resident rooms. The caulking around the sink was compromised in resident rooms 117, 121, 203, 210, 219 and 223. The over the bed light pull cord was missing in resident rooms 116 B, 218B and 225A. The clock in resident room 214 was not working. The privacy curtain in room 225</p>	<p>F 441</p> <p>F 465</p>	<p>F465</p> <p>1. The countertops and sinks were replaced by the licensed contractor in rooms 117, 121, 203, 210, 219, and 223 by 2/22/12. The over bed light pull cord was replaced for rooms 116B, 218B, and 225A on 1/6/12 by the Maintenance Director. A replacement battery was installed for the clock in room 214 on 1/6/12 by the Maintenance Director. The privacy curtain in room 225A was removed and the resident provided with a clean privacy curtain on 1/25/12 by the Housekeeping Supervisor. The wall surface in rooms 212 and 214 was repaired on 1/30/12 by the Maintenance Director. The air conditioning units in rooms 108 and 206 were cleaned by the Maintenance Director on 1/27/12. The sink handle in room 111 was replaced on 1/9/12 by the Maintenance Director. The faucets in rooms 203, 210, 221 and 223 were replaced by the Maintenance Director on 2/5/12. The shared bathroom for rooms 212/214 and 222/224 was cleaned by the housekeeper on 1/7/12 and double-checked by the Housekeeping Supervisor on 1/9/12. Room 219 three drawer cabinet was repaired on 1/16/12 by the Maintenance Director.</p> <p>2. Rounds were completed on 2/1/12 with the Administrator, Director of Nursing Services, Housekeeping Supervisor,</p>	
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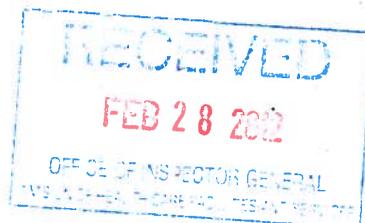
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F 465	<p>Continued From page 55</p> <p>was soiled with brown spots. The wall surface in resident room 212 and 214 was cracked between air conditioning unit and the window. The air conditioning units in resident rooms 108 and 206 had a white powdery, loose substance and loose particles in the vents. The hot water sink handle was loose in resident room 111. The faucet in resident rooms 203, 210, 221 and 223 was in disrepair.</p> <p>The findings include:</p> <p>Observed, on 01/03/12 at 7:40 PM, during the facility tour and on 01/06/12 at 1:00 PM, the over the bed light pull cord was missing in resident rooms 116B, 218B and 225A. The facility clock on the wall in resident room 214 was not working.</p> <p>Observed, on 01/05/12 at 10:20 AM and the facility tour on 01/06/12 at 1:00 PM, the caulking around the sink was compromised in resident rooms 117, 121, 203, 210, 219 and 223. The privacy curtain in room 225 was soiled with brown spots. The wall surface in resident room 212 and 214 was cracked six (6) inches between the air conditioning unit and the window. The air conditioning units in resident rooms 108 and 206 had a white powdery, loose substance and loose particles in the vents. The hot water sink handle was loose in resident room 111. The faucet in resident rooms 203, 210, 221 and 223 was in disrepair and had a build up of white soapy substance, green particles and red substance. The sink was dripping water and had a white build up on the faucet in resident room 223. The shared bathroom for resident rooms 212/214 and</p>	F 465	<p>Maintenance Director, and Regional Director of the contracted housekeeping provider to identify any issues related to a safe, functional, sanitary, and comfortable environment. Identified concerns were addressed by 2/22/12.</p> <p>3. Re-education was completed with Administrative Staff, Nursing Staff, Housekeeping Staff, Maintenance Staff, Dietary Staff and Therapy Staff on maintaining safe, functional, sanitary, and comfortable environment by 2/5/12 by the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and/or Nursing Supervisors. Education includes the location of Maintenance Requests and completing the request.</p> <p>4. Room rounds will be completed by the Administrator, Maintenance Director and/or Housekeeping Supervisor three (3) times weekly for four (4) weeks, then weekly for two (2) months, then monthly for three (3) months to determine a safe, functional, sanitary, and comfortable environment is maintained. Rounds will include caulking around sinks is intact, over bed pull cords are in place, clocks are functional, privacy curtains are clean, wall surfaces in good repair, air conditioning units clean, and sink handles and faucets are in good repair. Any concerns identified will be addressed/corrected as soon as possible. The</p>		

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F 466	<p>Continued From page 56</p> <p>222/224 smelled of urine. The quarter round trim and the formica counter top was loose and the three (3) drawer cabinet was not functional for use in resident room 219.</p> <p>Interview, with the Director of Maintenance, on 01/06/11 at 1:00 PM revealed he does room checks and responds to request by the staff when repairs in the room was identified and reported. He reported the build up around the faucets was water and calcium build up and rust in areas. He reported the areas on the faucets were not able to be cleaned thoroughly. He reported he was not aware the light cords were not replaced in the resident rooms. He reported the sinks and cabinets were on schedule to be changed, however, was unable to produce documentation of the scheduled update.</p> <p>Interview, with the Director of Housekeeping, on 01/06/11 at 1:00 PM, during the administrative facility tour revealed the sinks was not thoroughly cleaned due to the faucets with a build up of calcium and other particles. She reported bacteria could harbor in the surfaces when not cleaned thoroughly. She reported the air conditioning units in resident rooms 108 and 208 was properly cleaned. She reported she did not have a system in place to check off each area if needed for repairs, she reported she just looked into the room. She reported they do a terminal clean when a resident leaves or moves.</p> <p>Interview, with the Administrator, on 01/06/11 at 1:00 PM, during the administrative facility tour revealed the housekeeping service was not satisfactory. She reported this was an outside contract. She reported she did not have a</p>	F 466	<p>Administrator will report results of rounds to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p><i>S. 2/24/12 2-19-12 pusher by PB 3-13-12</i></p>	



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F 465	Continued From page 57 management tracking system in place at this time for housekeeping or maintenance.	F 465			

